city & hackney
safeguarding
children
partnership

Annual Report
2020-2021

Foreword

During 2020/21, the COVID-19 pandemic thoroughly tested every part of our local safeguarding arrangements in the City of London and Hackney. In these unprecedented times, safeguarding partners, relevant agencies and others connected with the CHSCP, not only demonstrated their professional commitment, but an ability to flex and do whatever it took to keep our children and young people as safe as we could. For this, I am immensely proud. You should be too.

As an immediate response to the first lockdown, the partnership reviewed its meetings framework, and adapted its priorities to focus on how best to maintain services in a rapidly changing environment. We scaled back several forums and introduced Contingency Oversight Group (COG) meetings. The COGs ensured that partners could frequently address issues linked to the health and well-being of the workforce, identify emerging safeguarding trends (including our line of sight on the young and vulnerable), and spot early issues impacting on the sufficiency of our inter-agency systems.

Alongside focused reassurance activity with partners, we supported targeted awareness raising on issues such as children's mental health, hospital attendance and accidents at home. We pivoted to online training sessions, with participation matching our 2019/20 numbers and in response to the increased threat of online harms, the Safer Schools App was rolled out to schools, parents and carers. This built on our commitment to utilise innovative technology to ensure the information people need to stay safe is always at hand.

With regards to the day-to-day work involving safeguarding children, this continued, albeit in an environment that has never been seen before. Despite such challenges, this report contains numerous examples of the **evidence, assurance, impact and learning** that has been accrued over the reporting period. It includes accounts of how front-line practitioners across all sectors have truly gone above and beyond.

Getting the basics right has been one of the clear strategic priorities for safeguarding partners for some time. This has never been more important during this period of uncertainty. Making sure that our practice reflects the principles of 'safeguarding first', 'context' and 'professional curiosity and challenge' are as relevant now as they have ever been.

At the time of writing, the reports into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson, alongside the publication of our own reviews, further illustrate the necessity for children to be 'seen, heard and helped'. I cannot understate the importance of these basic tenets of practice and the need for the government, in partnership with local organisations, to create the conditions whereby strong leadership, a stable workforce, manageable workloads and an appetite to learn allow this to happen.

Last year, I mentioned the fact that the timing of the report does not always assist those in leadership roles to make decisions based on the nature of immediate, contemporary and emerging safeguarding threats. To this end we made a commitment in 2019/20 to produce more routine strategic threat assessments. Whilst securing funding from the Department for Education, we have struggled with recruiting to the analyst role identified to deliver this initiative. Efforts continue and I am optimistic we will soon be able to report positive news in this regard.

Jim Gamble QPM

Independent Child Safeguarding Commissioner

The City & Hackney Safeguarding Children Partnership

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About the Annual Report

About the Annual Report

The City & Hackney Safeguarding Children Partnership annual report for 2020/21 sets out examples of the impact, evidence, assurance and learning arising from the safeguarding arrangements in the City of London and the London Borough of Hackney. It covers and reports on activity between 1st April 2020 and 31st March 2021 and includes the following:

- The governance and accountability arrangements for the CHSCP's safeguarding arrangements.
- The context for safeguarding children and young people in the City of London, highlighting the progress made by the City partnership over the last year.
- The context for safeguarding children and young people in the London Borough of Hackney, highlighting the progress made by the Hackney partnership over the last year.
- The lessons that the CHSCP has identified through its Learning & Improvement Framework and the actions taken to improve child safeguarding and welfare as a result of this activity.
- The range and impact of the multi-agency safeguarding training delivered by the CHSCP.
- The CHSCP's priorities going forward and the key messages for those involved in the safeguarding of children and young people.

IMPACT EVIDENCE ASSURANCE LEARNING

Glossary

Glossary

ABH	Actual Bodily Harm
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAFCASS	Children & Family Court Advisory and Support Service
CAIT	Child Abuse Investigation Team
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDR	Child Death Review
CHSAB	City and Hackney Safeguarding Adults Board
CHSCB	City and Hackney Safeguarding Children Board
CHSCP	City and Hackney Safeguarding Children Partnership
CHYPS	City and Hackney Young People's Service
CPP	Child Protection Plan
CRIS	Crime Reporting Information System
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CYPPP	Children and Young People's Partnership Panel
DBS	Disclosure and Barring Service
DfE	Department for Education
DVIP	Domestic Violence Intervention Project
EIP	Early Intervention and Prevention
ELFT	East London NHS Foundation Trust
ESOL	English for Speakers of Other Languages
FGM	Female Genital Mutilation
FGMPO	Female Genital Mutilation Protection Order
FJR	Family Justice Review
FRT	First Response Team
GLA	Greater London Authority
GP	General Practitioner
HCVS	Hackney Council for Voluntary Service
HLT	Hackney Learning Trust
HUHFT	Homerton University Hospital NHS Foundation Trust
ICSC	Independent Child Safeguarding Commissioner
IRI	Independent Return Interview
LA	Local Authority
LAC	Looked After Child / Children
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAP	Multi Agency Panel
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASE	Multi Agency Sexual Exploitation
MAT	Multi Agency Team
MPM	Management Planning Meeting
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education, Children's Services and Skills
PPU	Public Protection Unit
PSHE	Personal, Social and Health Education
PSP	Pupil Support Plans
SCR	Serious Case Review
SDVC	Specialist Domestic Violence Court
SEND	Special Educational Needs and Disability
SLT	Senior Leadership Team
SRE	Sex and Relationship Education
TRA	Tenant Resident Association
TUSK	Things You Should Know (CHSCP briefing)
UASC	Unaccompanied Asylum-Seeking Children

The CHSCP

Summary

The City of London and Hackney Safeguarding Children Partnership (CHSCP) is established in accordance with the Children Act 2004 (as amended by the Children and Social Work Act 2017) and the statutory guidance issued within Working Together to Safeguard Children 2018. The CHSCP's safeguarding arrangements define how safeguarding partners, relevant agencies and other organisations work together to coordinate their safeguarding services. These arrangements meet the requirements of statutory guidance and include details about how safeguarding partners will identify and respond to the needs of children, commission and publish local child safeguarding practice reviews and provide for independent leadership and scrutiny. The published arrangements are available HERE.

Purpose

The CHSCP's safeguarding arrangements support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted.
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies challenge appropriately and hold one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate accurate and timely decision making for children and families.

Vision

That all children in the City of London and Hackney are seen, heard and helped; they are effectively safeguarded, properly supported and their lives improved by everyone working together.

Principles

As leaders across a range of organisations, the commitment of the CHSCP is to work together to make the lives of children safer by protecting them from harm; preventing impairment to their health and/or development, ensuring they receive safe and effective care; and ensuring a safe and nurturing environment for them to live in. The CHSCP wants to make sure that everyone who works with children across the City of London and Hackney has the protection of vulnerable children and young people at the heart of what they do. In practice, this means that children are seen, heard and helped:

- **Seen;** in the context of their lives at home, friendship circles, health, education and public spaces (both off-line and on-line).
- **Heard;** by professionals taking time to hear what children and young people are saying - putting themselves in their shoes and thinking about what their life might truly be like.
- **Helped;** by professionals remaining curious and by implementing timely, effective and imaginative solutions that help make children and young people safer.

The CHSCP's aim is to ensure that safeguarding practice and outcomes for children are at least good, and that staff and volunteers in every agency, at every level, know what they need to do to keep children protected, and communicate effectively to ensure this happens. All of our activity is underpinned by the following principles:

- **Safeguarding is everyone's responsibility.** As a partnership, we will champion the most vulnerable and maintain a single child-centred culture.
- **Context is key.** Capitalising on the unique opportunities presented by a dual-borough partnership, we will have an unswerving focus on both intra-familial and extra-familial safeguarding contexts across the City of London and the London Borough of Hackney.
- **Anti-Racist practice is key.** The CHSCP's safeguarding arrangements are proactively anti-racist. Our focus in this context moves beyond the rhetoric and is evident in our leadership, our practice and in the outcomes of the children, young people, and families we engage.
- **The voice of children and young people.** We will collaborate with children and young people and use their lived experience to inform the way we work. We will regularly engage with them as part of our core business and ensure their voices help both design and improve our local multi-agency safeguarding arrangements.
- **The voice of communities.** Improving our understanding of the diverse communities across the CHSCP's footprint, we will regularly communicate with, listen to, and engage local communities in the work of the CHSCP. We will harness their experience to both inform and improve the way we safeguard and promote the welfare of children and young people.
- **Enabling high quality safeguarding practice.** We will promote awareness, improve knowledge and work in a way that is characterised by an attitude of constructive professional challenge.
- **Fostering a culture of transparency.** We will enable the CHSCP to learn from individual experience and continuously improve the quality of multi-agency practice.

Key Roles & Relationships

SAFEGUARDING PARTNERS

The safeguarding partners agree on ways to co-ordinate safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning. All safeguarding partners retain an equal and joint responsibility for local safeguarding arrangements. In situations that require a single point of leadership, safeguarding partners will decide on which partner will take the lead on relevant issues that arise. The safeguarding partners in the City of London and the London Borough of Hackney are Hackney Council, The City of London Corporation, The City & Hackney Clinical Commissioning Group (CCG), The Metropolitan Police Service (MPS) and The City of London Police. The lead representatives of the safeguarding partners during 2020/21 were:

- **Tim Shields, The Chief Executive of Hackney Council**
- **John Barradell, The Town Clerk of the City of London Corporation**
- **Jane Milligan, The Accountable Officer of the City & Hackney CCG**
- **Marcus Barnett, The Commander of the MPS Central East BCU**
- **Ian Dyson, Commissioner, City of London Police**

RELEVANT AGENCIES

Safeguarding partners are obliged to set out which agencies are required to work as part of the CHSCP's arrangements to safeguard and promote the welfare of local children. These agencies are referred to as relevant agencies and have a statutory duty to cooperate with the CHSCP's published arrangements. A defined number of relevant agencies meet regularly with safeguarding partners as the CHSCP Executive. Others are invited when deemed necessary and/or be included in various CHSCP sub-groups / thematic groups. Wider engagement events will also be facilitated through the City & Hackney Safeguarding Partnership which includes a much broader range of agencies, professionals and volunteers involved in safeguarding children and young people. A schedule of relevant agencies is defined in part 4 of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

OTHER NAMED ORGANISATIONS

Safeguarding partners can also include any local or national organisation or agency in their arrangements regardless of whether they are named relevant agencies. Whilst not under the same statutory duty, there remains an expectation of compliance, with legal powers existing in defined areas. For example, Section 16H of the Children Act 2004 contains a wider power exercisable by the safeguarding partners to request a 'person or body' to provide information to them. There is no limitation or definition of 'person or body' therefore the request can be made to anyone. Local organisations named by the CHSCP include:

- All 'Out of School Settings' providing tuition, training, instruction or activities without the supervision of parents or carers.
- Social Housing providers.

THE INDEPENDENT CHILD SAFEGUARDING COMMISSIONER

Jim Gamble QPM is the Independent Child Safeguarding Commissioner (ICSC) of the CHSCP. The ICSC is appointed by safeguarding partners and given authority to coordinate the independent scrutiny of the local child safeguarding arrangements. The ICSC is fundamentally independent to local safeguarding partners and relevant agencies. The ICSC has significant experience of operating at a senior level in the strategic coordination of multi-agency services to safeguard and promote the welfare of children.

ASSURANCE

Through engagement, commentary, and lobbying, the ICSC provides independent leadership in respect of local matters relevant to the safeguarding of children and young people. The ICSC holds both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. The ICSC chairs the CHSCP's Strategic Leadership Team and the CHSCP Executive to ensure fundamental independence is built into the oversight of statutory safeguarding partners and relevant agencies. The ICSC also chairs the Case Review sub-group to ensure independent decision making in respect of the commissioning and progress of reviews. The ICSC continues to be engaged with elected officials to brief on specific issues, raise concerns and to provide an independent overview of practice. This takes place via 1:1 meetings and other forums (such as 'joint chairs' meetings) and those that engage elected members and other local boards (Health & Wellbeing / SAB / CSP). The ICSC is also engaged by the Local Authority scrutiny functions in both the City of London and Hackney.

THE STRATEGIC LEADERSHIP TEAM

The Strategic Leadership Team (SLT) are senior officers that can speak with authority for the safeguarding partner they represent. They can hold their organisation to account, take decisions and commit them on policy, resourcing and practice matters. The SLT is chaired by the Independent Child Safeguarding Commissioner and during 2020/21, comprised the following:

- **Anne Canning, The Group Director of Children, Adults and Community Health (Hackney Council)**
- **Andrew Carter, The Director of Children and Community Services (The City of London Corporation)**
- **David Maher, The Managing Director (The City & Hackney CCG)**
- **Marcus Barnett, The Commander of the MPS Central East BCU**
- **Dai Evans, T/Commander, City of London Police**
- **Annie Gammon, Director of Hackney Education (Hackney Council)**

THE CHSCP EXECUTIVE

The CHSCP Executive comprises representatives from safeguarding partners and several relevant agencies. It includes named / designated professionals. It is independently chaired by the and is responsible for delivering the CHSCP business plan and mitigating any identified risks. The core membership of the CHSCP Executive can be found HERE.

THE CHSCP TEAM

The CHSCP is supported by a dedicated group of staff. The team includes a Senior Professional Advisor, a Business and Performance Manager, a Training Co-ordinator and a Co-ordinator role.

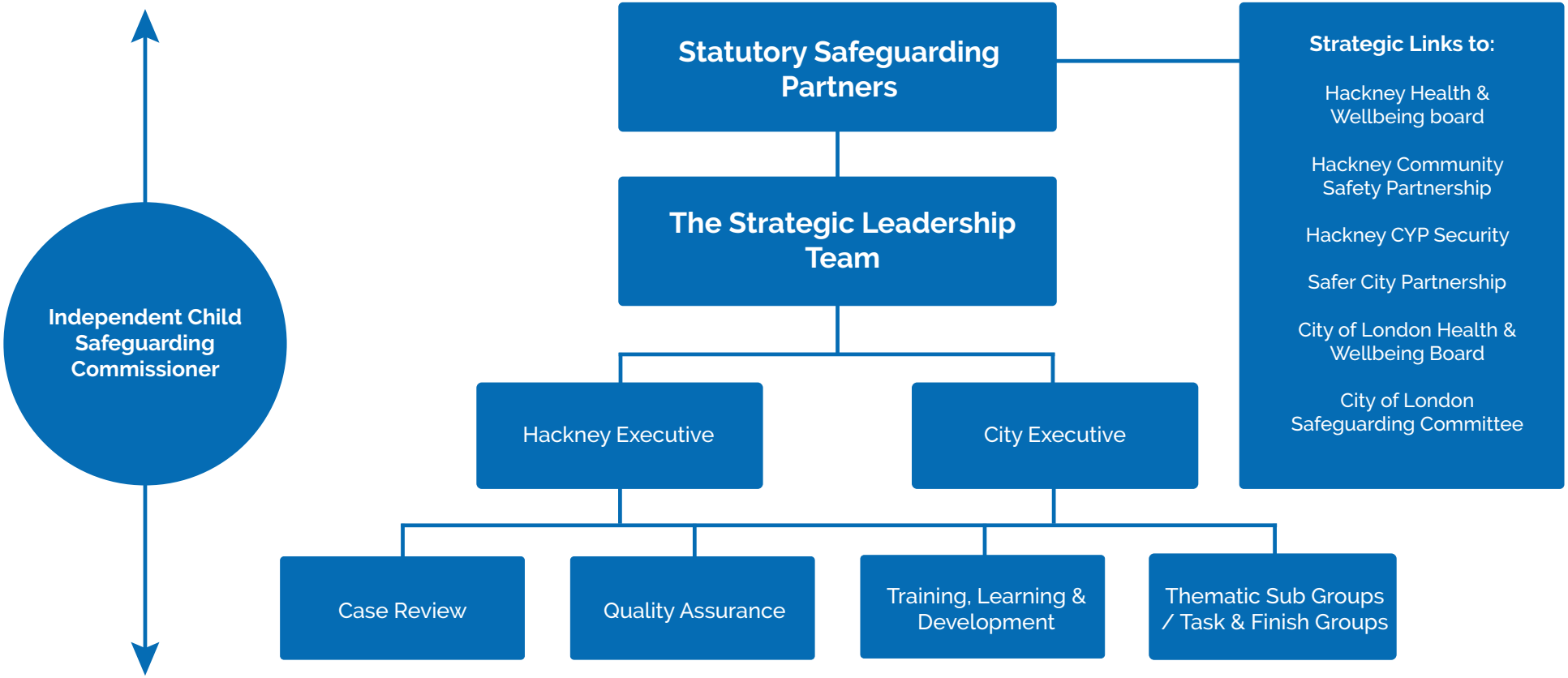
RELATIONSHIPS WITH OTHER BOARDS

Continued engagement with the City & Hackney Safeguarding Adults Board (CHSAB) and other strategic partnerships in the City of London and Hackney was frustrated but continued during 2020/21.

EVIDENCE

Working collaboratively with the CHSAB, the Transitional Safeguarding Task and Finish Group led on an exercise asking organisations working with young people aged 16 - 25 years old about the safeguarding issues affecting young people. The group used this information to create a brief outlining the safeguarding issues affecting young people and an action plan on how to take this work forward. A transitional safeguarding action plan was developed, which focusses on Information gathering / Engagement activity and Partnership and awareness raising.

CHSCP Structure 2021



Note: In 2020/21, the CHSCP operated with a combined Executive group covering the City of London and Hackney.

Financial Arrangements

IMPACT

As part of its Corporate Social Responsibility (CSR) programme, INEQE Safeguarding Group continues to support the local partnership in the production of its annual report.

Serious Case Reviews	£10,649
Staffing and Travel	£283,963
Training & Learning Management System	£9,909
Printing, supplies and Equipment	£3,489
Venues	£0
Miscellaneous	£0
Total Expenditure	**£308,010**

COVID-19

Whilst the contexts of safeguarding are different across the City of London and Hackney, the three biggest challenges facing multi-agency safeguarding work over 2020/21 remained as follows:

- The impact of COVID-19 creating challenges in respect of the sufficiency of current and future workforce capacity. Contingency arrangements in this regard were scrutinised by the CHSCP. Whilst evidence of resilience, there remains concern as to the potential for future workforce challenges. These centre on the longer-term effects on the mental health of practitioners arising from extended periods of remote working in a highly charged and challenging area of practice.
- Support systems for children and young people (via school, services, friends and family) changed over 2020/21 and were either reduced or removed. Children and young people were less visible and families were under increased financial and social pressure.
- Increasing demand in respect of specific needs and risks.

The priority for the CHSCP is to ensure that our children are **seen, heard and helped**. We cannot do this if we are unable to support and sustain a motivated, healthy and engaged multiagency workforce, identify emerging safeguarding themes and ensure ongoing interagency interoperability. To this end, Contingency Oversight Group (CoG) meetings were set up in response to Covid-19 and held in both the City of London and Hackney.

EVIDENCE

The pandemic highlighted the invisibility of vulnerable children and the increase in safeguarding risks that they faced. Throughout the series of lockdowns there was restricted access to services and reduced school attendances for all children, coupled with parental perception that it was unsafe for them and their children to use health services even when they were ill because of their fears of getting Covid. The issues reported nationally were reflected locally i.e., an increase in domestic abuse notifications. Paediatricians reported a significant reduction in children attending emergency departments with an associated reduction in child protection referrals. Some children presented very late and seriously ill when they should have been seen earlier. Despite the reduction in presentations, when children presented, they had quite significant safeguarding issues for example in the first lockdown there was an increase in the number of children under one with head injuries, one of which resulted in a local child safeguarding practice review being undertaken locally. There has been an increase in children with emotional disorders (e.g., eating disorders) and over a 50 percent increase in CAMHS referrals. The pandemic has had and will continue to have an adverse impact on the health and wellbeing of children. CCG Annual Report 2020/21

IMPACT

CoG meetings identified emerging issues throughout 2020/21 such as attendance at A&E, domestic violence, mental health, a local increase in head injuries to babies / toddlers and risks arising from hazards in the home. This led to a focused approach by safeguarding partners on targeted awareness raising, developing specific guidance and delivering training. During the pandemic, partners also swiftly pivoted to providing digital solutions to ensure that agencies were engaged (despite not being able to physically meet). Multi-agency processes such as strategy discussions, child protection conferences and visits to children were all undertaken virtually where required.

IMPACT

During the pandemic, partners also swiftly pivoted to providing digital solutions to ensure that agencies were engaged (despite not being able to physically meet). Multi-agency processes such as strategy discussions, child protection conferences and visits to children were all undertaken virtually where required.

ASSURANCE

*The CHSCP prepared for further challenges by ensuring that safeguarding partners and relevant agencies had clear plans in place and that they were sufficiently prepared. This was achieved by conducting a **COVID-19 Operational Resilience Audit**. A major focus of this audit activity related to workforce sufficiency and the cruciality of safeguarding partners ensuring effective support is in place across the system. Whilst the CHSCP had already identified the health and wellbeing of the workforce as a priority, Covid-19 accelerated reassurance activity in this respect.*

88% of organisations either partially or fully identified best practice and agreed pathways for staff to access occupational health support.

96% of organisations had a risk assessment process which assessed the risk to individual employees from the COVID-19 virus. It identified increased risks due to staff's age, ethnicity, gender and relevant health conditions.

93% of organisations ensured staff who had suffered bereavement, due to COVID-19 or other reasons, were supported to access specialist support services and that there were policies and practices in place for pastoral support of staff.

Communication

The CHSCP continues to promote its digital platforms and communications reach. The CHSCP website design was refreshed over 2020/21.

THE CHSCP WEBSITE

The CHSCP website has continued to allow for user-friendly content searches and accessible resources. The most visited pages continue to be those relating to training and case reviews.

www.chscp.org.uk

TWITTER

@lscp_chscp

PRIVATE FOSTERING APP

Following the success of the City of London Private Fostering App, the CHSCP developed and launched a bespoke App for the partnership. Alongside providing information about private fostering, the App includes a training module and other important advice for safeguarding professionals.

TUSK BRIEFINGS

The CHSCP produces e-briefings called Things You Should Know, more commonly referred to as 'TUSK briefings'. These are circulated to subscribers and also cascaded by safeguarding partners, relevant agencies and named organisations. The number of subscribers to the TUSK remained broadly static over 2020/21, increasing from 1414 to 1432.

Technology & Social Media

With the growing use of technology and social media, all professionals need to adopt a much more sophisticated approach to their safeguarding responsibilities. They need to reflect on the changing nature of communication and how this impact upon practice issues, particularly those focused on the identification and assessment of potential risk. To do this successfully, professionals need to recognize that children and young people do not use technology and social media in isolation. Their offline and online worlds are converged, and both need to be understood when trying to identify the type of support that a child, young person and their family might need.

To help professionals (and parents / carers) better understand this complex environment, new Apps have been launched by Hackney Council and the City of London Corporation. The Safer Schools App provides support on topics including online bullying, mental health, sexting, media literacy, gaming and sexual exploitation online. It costs nothing to download and provides access to advice, guidance and CPD accredited training, with a specific focus on making children and young people safer in the online world.

City Safeguarding Snapshot

1,825 children and young people under 18

16.7% of total population

12% of children living in poverty

13.7% of children in primary schools in receipt of free school meals (national average 20.8) (Jan2021)

12 cases referred / stepped-down to the City's Early Help Team

46 Team around the Child (TAC) meetings held

5 young people going missing from care (12 incidents)

0 incidents of children & young people missing from home

259 contacts to the City Children & Families Team Hub

62 referrals

9.7% re-referrals

44 statutory social work assessments completed by The City Children & Families Team

72% of assessments completed within 45 days

5 child protection investigations

3 children on a Child Protection Plan as of March 2021

131 Children in Need episodes as of March 2021 (101 in 2019/20)

20 children & young people looked after as of March 2020

6 MARAC meeting involving children

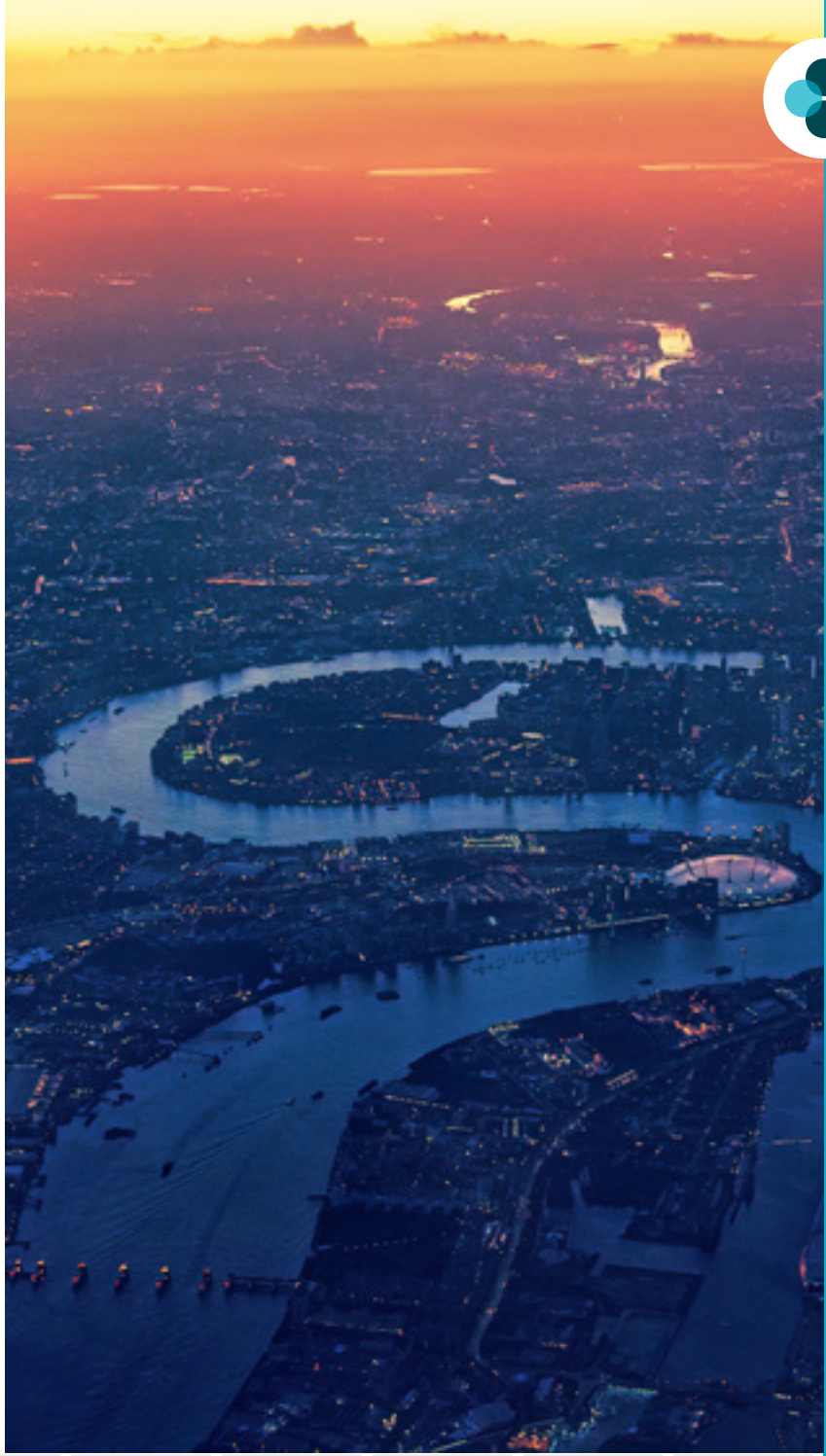
15 referrals to the LADO

0 Private Fostering arrangements as of March 2020

Safeguarding in The City of London

City of London Demographics

The City of London has an estimated resident population of about 8500 and a transient daytime working population of around 330,000. Of the resident population, approximately 16.7% are children and young people. The City of London is an economically diverse area, with its population characterised by areas of affluence and poverty. Within the Square Mile, there are large disparities. The Barbican West and East residential areas are among the most affluent areas in England. Portsoken Ward, however, is among the most deprived. An estimated 78% of the City of London population is White British; however, approximately 40% of children are from black or ethnic minority groups compared to 21% nationally. The Bangladeshi community makes up 4% of the total population. Domestic abuse remains a key issue in the City with the majority of child protection investigations in the City involving domestic abuse concerns. There are no children involved in the criminal justice system currently and no teenage pregnancies. Academic attainment for City resident children is higher than the national average. The numbers of children and young people Not in Education, Employment or Training (NEET), obesity rates, infant deaths and underweight babies, hospital admissions for self-harm, deliberate injury, alcohol-related injury and the number of pregnant smokers are all low with numbers ranging from 0 to 5 in each category. Within the City, there is one maintained primary school (with a Children's Centre attached), four independent schools and several higher educational establishments. It has no maintained secondary schools. The majority of children attending these schools come from other boroughs and most of the local authority's secondary school age children go to school outside of the City.



Early Help

Early help services across the City of London are delivered by People's Services and a range of partners, including schools, children centres, one GP surgery and health colleagues as well as other local service providers, including the community and voluntary sector. They are effective, and some are particularly strong. The range of services available to children, young people and their families in the City continue to adapt and evolve based on the needs of the local population. The early help arrangements in the City have been in place now for a number of years and are embedded with agencies. All children needing an early help service in the City receive a well-resourced, dedicated service, which is provided by trained staff. Over 2020/21, the Early Help Strategy for the City of London continued to drive partnership improvements. With a focus on ensuring the right help is provided at the right time and in the right place, the strategy is focussed on key strategic objectives and is coordinated by the CHSCP City Early Help Sub-Group. Through critical reflection, consultation and co-production with children and families, partners from the Multi-Agency Practitioners Forum and the City's Parent Carer Forum for children with SEND, the following progress has been made:

EVIDENCE

In 2020/21, the total number of cases referred or stepped down to early help services was 12, a reduction from 21 in 2019/20. This reflects the reduction in activity seen nationally as a consequence of the Covid-19 lockdowns. There were no re-referrals to early help within 12 months of closure. This has been a consistent pattern and reflects the effectiveness of the multi-agency intervention to improve outcomes for children and young people, preventing problems getting worse.

ASSURANCE

'Work is appropriately held within early help, and there is evidence of good direct work with families to effect change. There is effective engagement with partner agencies to support individual families, and, strategically, to develop the early help service further.' OFSTED 2020

ASSURANCE

The City of London has a clear Thresholds of Need document that has been agreed with partner agencies. This is used to provide services at an appropriate stage and as early as possible to prevent higher levels of need in the future.

There is a single point of contact for referrals to Early Help services and Children's Social Care, enabling timely and appropriate decision making and allocation.

The Early Help Assessment is co-created with the family, including discussions with the child/ young person as well as with practitioners from involved agencies.

*Early help practice in the City of London is **Empowered**: evidenced through insightful assessments by highly skilled staff, that lead to robust offers of help. **Child-centred**: evidenced by children and young people routinely being present at meetings or represented through direct work. **Integrated**: evidenced through a strong 'Think Family Focus', and a 'top-three' (cases of concern) collaboration across children's, health, adult, housing and homeless service.*

Children in Need of Help and Protection

Good practice with children and young people who are in need of help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated and outcomes improved through good assessment, authoritative practice, planning and review.

ASSURANCE

'Children in need of help and protection within the City of London receive a good service that is proportionate to their needs and enables them to effect positive change. Risks to children are minimised and, where required, additional support is provided to prevent concerns from escalating.' OFSTED 2020.

ASSURANCE

The City of London Corporation undertook a virtual visit thematic audit in May 2020. This showed that social workers were aware of the potential deficits in using virtual visits to assess and manage risk. There was evidence when comparing the quality between face to face and virtual visits that social workers had taken this into consideration by following the guidance they had been given. Telephone contact did not give the same depth or quality of information required, as audits completed using this method showed that the interaction was rather one-dimensional. Where possible, video/face to face visits were used. Since August 2020, all visits have been face-to-face, unless there are risk factors which require alternative planning. Data shows a large increase in fact to face visiting for quarter 3.

Contacts, Referrals and Assessments

The Children and Families Team Hub provides responsive screening activities and ensures all contacts are immediately progressed as a referral if the threshold for a statutory social work assessment is met. Signposting activity requires staff to have a continually updated knowledge of local services alongside a comprehensive understanding of the City of London Thresholds of Need. The Children and Families Team Hub aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found HERE.

EVIDENCE

The 259 contacts made to the Children and Families Hub reflects a decrease on previous years and again, this will be related to the lockdown arrangements because of Covid-19. Referrals similarly decreased from 100 in 2019/20 to 62 over 2020/21. The re-referral rate in the City of London was 9.7%, a reduction from 15% in 2018/19. Notwithstanding the reduced demand during 2020/21, the performance data in the City continues to be indicative of a good social work response and timely access to appropriate support that helps children and their families. The Children and Families Team completed 44 assessments during 2020/21, compared to 67 in 2019/20. 72% of assessments were completed within 45 days or less. There were five child protection (Section 47) enquiries in 2020/21, a reduction from 20 recorded in the previous year.

ASSURANCE

Despite the clear challenges arising from identification of need and risk, children continued to receive a swift service during 2020/21 when safeguarding concerns became apparent. All Section 47 enquiries undertaken in the City are led by a suitably qualified and experienced registered social worker.

CHILDREN ON CHILD PROTECTION PLANS

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP). Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how professionals, the family and the child or young person (where appropriate) will know when progress is being made. Three children were subject to a CPP in the City at the end of 2020/21.

ASSURANCE

'When children are identified as being at risk, strategy meetings are convened in a timely manner and are well attended by professionals, who provide relevant information to inform decision-making. Decisions following these meetings and any subsequent enquiries are clearly recorded by managers to facilitate effective interventions with families.' OFSTED 2020

Children in Care

A child or young person who is 'looked after' is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances, the City of London Corporation and partners will intervene because the child or young person is at risk of significant harm. As of 31 March 2021, the City of London Corporation was responsible for looking after 20 children and young people, a reduction from 24 in 2019/20. The City of London's rate for looked after children is well above statistical neighbours and proportionately, this reflects a high volume of work for the City of London social workers.

PLACEMENT STABILITY, TYPE AND LOCATION

In 2020/21, 5% of children looked after had three or more changes of placement over the year. This was one young person and an improvement from 2019/20. Caution should be observed in analysing these figures because variations of one or two children can have a major impact on the rate and this performance can therefore fluctuate. This continues to reflect good performance and means that children looked after by the City tend to enjoy good stability and placements that meet their needs well. The local authority does not have its own fostering service due to the size of the looked after children population, but spot purchases from the Pan London consortium. Ofsted rates all independent fostering agencies used by the City either Good or Outstanding. There are sufficient suitable placements available to meet the needs of the City's looked after children and young people. All placements are outside of the local authority, with nine young people being placed over 20 miles from the City.

ASSURANCE

An external audit commissioned by the City of London on Placement Stability took place in November 2020. This audit found examples of good and outstanding practice across twenty-five cases. Areas for improvement were identified in only a small number of cases. The audit concluded the overall quality of foster care and semi-independent placements was generally of a good standard. The City of London Corporation evidenced proactive mitigation (where mitigation was possible) against dominators which caused placement instability. Even when placement breakdowns were experienced, with its associated implications, good outcomes for young people are being achieved.

Care Leavers

There is a strong range of support for care leavers in the City of London. Care Leavers are well supported, workers remain in touch with them, there is availability of suitable accommodation, and they are provided with health support. 25 out of 39 care leavers were in education, training or employment; 1 in university, 20 attending college; 4 in employment, 12 Not in Education, Employment or Training (NEET) and 2 recorded as unknown (March 2021).

ASSURANCE

In some areas, particularly in relation to children in care and care leavers, services have improved, resulting in positive experiences and progress for young people. OFSTED 2020

Violence Against Women and Girls

Children and young people who are exposed to domestic violence and abuse can grow up in a vacuum of what is expected in terms of a positive and healthy relationship. This can create additional vulnerabilities and/or harmful behaviours. Responding proactively and in collaboration with the Safer City Partnership (SCP), violence against women and girls remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. During 2020/21, the Safer City Partnership continued its focus on developing services and a new **Violence Against Women and Girls Strategy.**

IMPACT

Operation Encompass has been rolled out by The City of London Police. The City's schools have completed the training which was delivered virtually due to COVID-19 restrictions. Training material has been delivered to all schools so they can refresh staff as and when required.

MARAC

Operational arrangements for MARAC (multi-agency risk assessment case conference) processes are clearly defined in the City of London. The City MARAC operates a lower threshold than in other local authorities and takes cases where a preventative approach would be helpful. This is good practice and enables children within these families to have a better co-ordinated multi-agency service.

EVIDENCE

In 2020/21, six MARACs were held where children were involved. This increase mirrors the patterns seen elsewhere across London and the UK in terms of domestic violence and abuse escalating during periods of lockdown.

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key. During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

The strategy continues to draw on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains a focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

CHILD SEXUAL EXPLOITATION

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

> *'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'*
>
> DfE 2017

The City of London continued to experience a low number of cases relating to Child Sexual Exploitation (CSE), with most contacts being about non- residents. Over the last four years, the crimes relating to CSE that have been recorded by the City Police include rape, sexual activity and possession of indecent images. Cases have also included grooming by offenders via the internet / social media. Partner agencies engaged in the City continue to share intelligence that may influence the knowledge of the profile. Of significance is the City's location as a major transport hub. A quarterly data set of over twenty indicators produced for the MASE Group supplements the information provided by the City Police. This informs understanding, and the identification of risk indicators. In recognition of the overlapping vulnerabilities adolescents face, the City Multi-Agency Sexual Exploitation panel was changed to the Multi-Agency Child Exploitation panel to include all forms of abuse and exploitation that adolescents are at increased risk of. Although few in number and type and relatively lower level risk in comparison to neighbouring LAs, the City is not complacent and maintains an 'it could happen here' stance.

CHILDREN MISSING FROM HOME, CARE AND EDUCATION

The City Police lead on all children who go missing from home or care and a coordinated response takes place with the City Children and Families team, working closely with the child's parents or carers. Numbers of children who go missing in the City of London are very low. A specific part of the Safeguarding Adolescent Strategy focuses on the effective management of children who are missing. The City of London has reviewed its Missing from Care Procedures and the arrangements for Return Home Interviews. There remains senior leadership oversight through the missing period with robust partnership arrangements in place. All strategy meetings have health, social care and police engagement as a minimum. This has helped with the timely response to missing episodes and alerting relevant authorities to missing episodes.

ASSURANCE

NCH Action for Children is commissioned by the City of London Corporation to give missing children a return home interview within 72 hours. These interviews are followed up with therapeutic support depending on the outcome to address risk-taking behaviour. This is in line with statutory guidance published by the Department of Education in 2014. Return home interviews are reviewed and used by the partnership to understand the reasons why children go missing and inform strategy and service delivery.

ASSURANCE

Since 2015, the City of London Corporation has implemented a rigorous system to identify all children of statutory school age and where they attend school. The City of London maintains this record of where children are placed through the primary and secondary transitions process. A school tracker is updated and reviewed regularly.

ASSURANCE

There is senior leadership oversight through the missing period with robust partnership arrangements in place. All strategy meetings have health, social care and police engagement as a minimum. This has helped with the timely response to missing episodes and alerting relevant authorities to missing episodes.

A Vulnerable Children's list includes missing and includes oversight by social care and education. This is currently reviewed monthly and throughout Covid-19 was reviewed weekly.

GANGS, CRIMINAL EXPLOITATION AND SERIOUS YOUTH VIOLENCE

There are several ways in which young people can be put at risk by gang activity, both through participation in and as victims of gang violence which can be in relation to their peers or to a gang-involved adult in their household. The City of London Drugs Profile found that the largest area of drug misuse was among affluent City workers with the supply of drugs controlled by organised criminal groups involving male 'runners' in their 20s who often deal pre-ordered drugs out of their cars. While drug related crime involving resident children and young people is low, a case involving a trafficked young person highlighted this as an emerging theme in the City that requires close attention and partnership working between Police, Adult and Children's Social Care, and businesses. There is concern in the north of the City that young adults known to be associated with Islington gangs have been seen around Golden Lane Estate. Community safety partners are monitoring this closely and report 'no hard issues' other than gang related graffiti to date. Work with the estate and Islington is needed to understand this emerging pattern and mitigate associated risks for CYP.

IMPACT

Work continues on the implementation of Operation Innerste, which is a process that enables police to obtain the fingerprints and photograph of unaccompanied asylum-seeking minors when they present at the police station. The aim of the operation is to provide an active deterrent to traffickers or potential exploiters Pilot schemes have seen it greatly reduce the number of minors who abscond from their placements and present in a different local authority area. During 2020/21, Operation Innerste training was delivered to all frontline police officers, with plans implemented for Children's Social Care staff to receive a streamlined package.

ADOLESCENT NEGLECT

Identifying, naming and responding to adolescent neglect can be challenging due to misconceptions that adolescents become more resilient because of their age alone, an over-reliance on older young people to be responsible for themselves, and the assumption that they can and will ask for help if needed. This is further exacerbated in affluent families where material wealth and access to private services can serve to keep neglect and emotional abuse of adolescents hidden. It is also the case that CYP in affluent families where there is parental substance misuse, mental ill health, or domestic violence can be harder to reach due to the way families use their resources to block access and can hide the extent of their needs through the use of privately funded services.

EVIDENCE

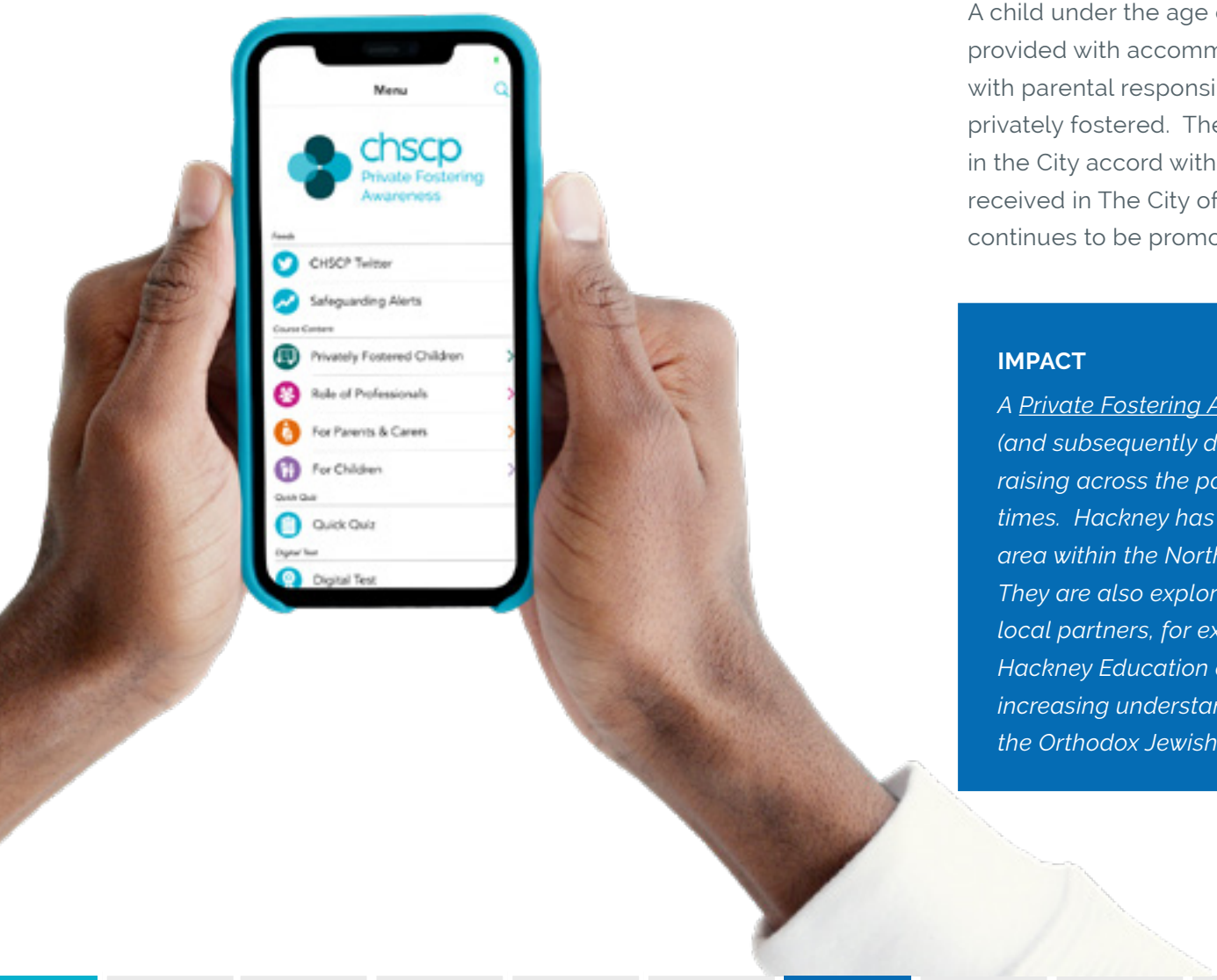
The City of London has previously sponsored research on neglect in affluent families. Conducted by Goldsmith University, this research identified teens as a particularly vulnerable cohort with complex safeguarding needs. Research by The Children's Society has also found a potential link between emotional neglect and those children living in more affluent families. Given the City's demographics, this remains a priority, ensuring that practitioners have the necessary skills to recognise and respond to the signs and symptoms of adolescent neglect.

SELF-HARM & SUICIDE

The partnership's focus on self-harm and suicide continued over 2020/21 as a consequence of the deaths of a number of young people from Hackney. Learning from the published reviews into these cases is set out later in this report. The City of London's Suicide Steering Group continued to provide strategic oversight and operational planning covering both adults and children.

RADICALISATION

The Counter Terrorism and Security Act received Royal Assent on 12th February 2015. Prevent was placed on a statutory footing in July 2015 to ensure all specified authorities in local areas, as a minimum, understand the local threat and take action to address it, assess if local frontline staff need training to recognise radicalisation, and to ensure that all of those who need to work together to deliver the programme do so in the most effective way. The City of London has not been identified as a Priority Area and as such, receives no additional Home Office funding to deliver its Prevent programme. The Safer City Partnership (SCP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The City of London Police delivers Prevent training to schools, youth providers and businesses.



Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. The arrangements for managing private fostering in the City accord with statutory requirements. No notifications were received in The City of London during 2020/21. Private Fostering continues to be promoted via the CHSCP Private Fostering App.

IMPACT

A Private Fostering App originally launched in the City of London (and subsequently developed by the CHSCP) to support awareness raising across the partnership has been downloaded nearly 7000 times. Hackney has worked closely with colleagues working on this area within the North London Consortium, to share best practice. They are also exploring opportunities to raise awareness with specific local partners, for example, looking at the admissions process with Hackney Education and local voluntary sector organisations about increasing understanding of the private fostering regulations within the Orthodox Jewish community.

Children with Disabilities

Since the introduction of the special educational needs and disability (SEND) reforms in September 2014, the City of London Corporation has made good progress in implementing these. All former Statements of Special Educational Needs were transferred to Education, Health and Care (EHC) plans well in advance of the national deadline of 1 April 2018. All statutory assessments are completed within 20 weeks (the statutory timeframe). There remains a very high level of satisfaction rate amongst families accessing the City of London's services and their view of multi-agency working is good. The SEND Joint Strategy and self-evaluation form (SEF) has been developed with both partners and families to set out the City's priorities and to highlight the areas where the most progress is being made.

IMPACT

The City of London provided short breaks to four children supported by Early Help and there were 20 children with EHC plans in place (January 202). There is a disability lead in the social work team who has specialist knowledge and supports the service when needing to progress assessment work with disabled children. During the Covid-19 pandemic, partners in the City of London have continued to offer close support to children with EHC Plans and their families through a weekly review and have a strong integrated offer between Special Educational Needs and Children's Social Care.

MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public from serious harm, by ensuring all agencies work together effectively.

EVIDENCE

Across London on 31 March 2021, there were 6549 Category 1 'Registered Sex Offenders' (RSOs) (6581 in 2019/20 and 6452 in 2018/19), 3521 Category 2 'Violent Offenders' (3735 in 2019/20 and 4128 in 2018/19) and 61 Category 3 'Other Dangerous Offenders' (31 in 2019/20 and 27 in 2018/19).

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a designated safeguarding lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the designated officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. Reporting to the Assistant Director of People Services, the LADO role in the City is held by the Safeguarding and Quality Assurance Service Manager. The LADO should always 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.

EVIDENCE

Activity *- There were 15 referrals made to the LADO during 2020/2021 period, which is an increase of 7 from 2019/2020. This increase has not been due to any significant surge in referrals, but how referrals and contacts are now being recorded. In the past only cases that went to an Allegation Against Staff and Volunteers (ASV) Meeting were recorded as a LADO, but this did not truly reflect the breadth of concerns and allegations that were being referred.*

EVIDENCE

Themes *- The highest proportion of referrals received by the LADO related to incidents that occurred in the professional's person life. Of the five referrals received in this category, two were related to child sexual offences, one was related to domestic abuse and two were related to the professional's behaviour in their personal life. The majority of these incidents were progressed through disciplinary procedures. The range of organisations involved included Health, Education and the voluntary sector.*

IMPACT

There was improved engagement with the LADO due to the accessibility enabled by virtual working. The speed at which meetings could be convened was also enhanced without availability being affected by travel, distance and room availability.

IMPACT

LADO Training & Awareness Raising *- Designated Safeguarding Leads accessed training through the CHSCP. Part of this training focuses on the role of the LADO. Face-to face training by the LADO was hindered over 2020/21 due to the pandemic, but key professionals remained engaged through the Safeguarding Education Forum and CHSCP meetings, including the Contingency Oversight Group meetings convened in the City of London.*

ASSURANCE

Practice audits of LADO work are conducted every 6 months by the Service Manager and Practice Development Managers in the Safeguarding and Reviewing Service. These consistently find timely responses from the LADO Service, positive working relationships between the LADO and partner agencies, clear actions and outcomes being achieved. What routinely remains problematic is a lack of written referrals/information being received from referrers, and partners not providing updates of feedback from their internal investigations as requested by the LADO. This results in additional work for the LADO in terms of having to outline phone conversations in emails so that the network is clear on advice provided and actions expected, and in following up requesting updates.

Hackney Safeguarding Snapshot

Approximately **63,828** children and young people under 18

23% of total population

30% of children living in poverty

479 children were subject to a CAF and MAT intervention in 2020/21

293 new early help cases identified and supported through the MAT process

11,473 contacts to Hackney CFS

2,093 referrals

18.6% re-referrals

3,664 assessments completed by Hackney CFS

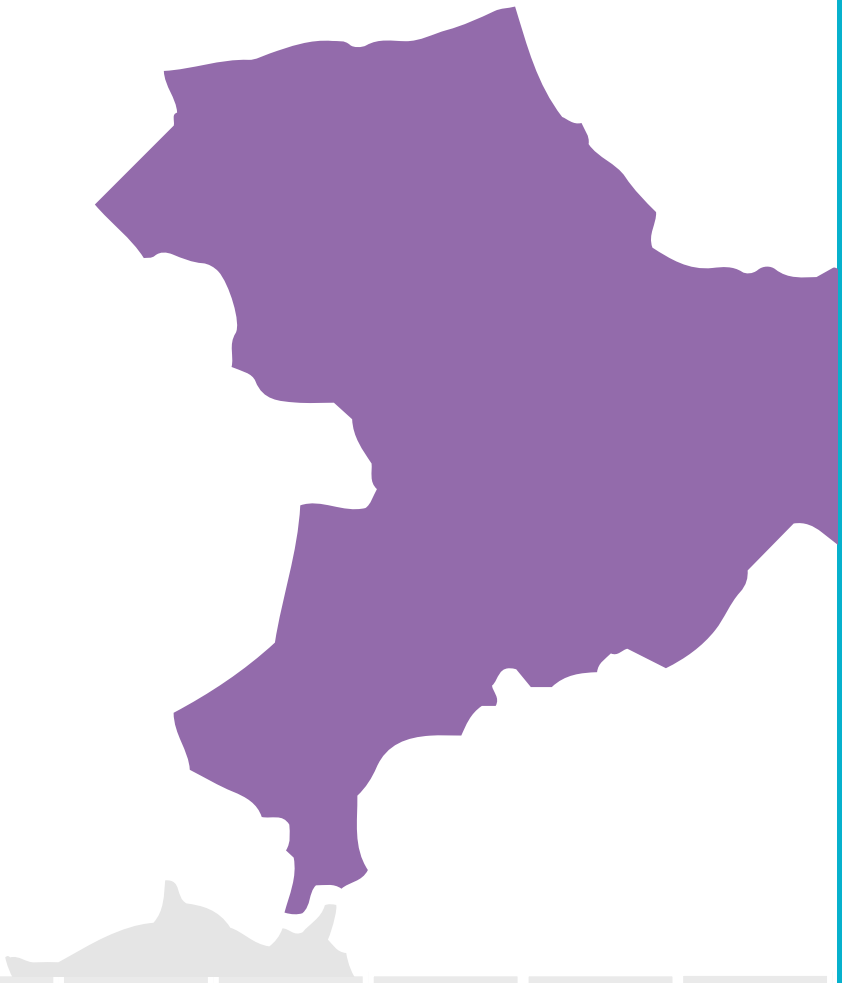
78% of assessments were completed within 45 days

836 child protection investigations

237 Children on a Child Protection Plan as of March 2021

426 children & young people looked after as of March 2021

279 MARAC meetings involving children and young people living in families with domestic violence



Safeguarding in Hackney

Cyberattack

Hackney Council was the victim of a serious cyberattack in October 2020. The attack meant that the social care management system (Mosaic) and document management systems (Comino and eDOCS) were unavailable, which has had a significant and widespread impact on Hackney's Children & Families Service (CFS). The cyberattack has affected the ability of the CHSCP to oversee the full suite of performance metrics relevant to CFS.

ASSURANCE

Hackney CFS continued to work to safeguard children and to support children and families following the significant impact of the cyberattack. It worked closely with partner agencies to share information where there were gaps in records in the immediate period after the cyberattack. This included the police establishing a team to carry out additional checks to support social workers to know the history of families in the absence of historic case records, and linking in with schools and health partners to gather information on children on CP Plans as a priority.

ASSURANCE

Hackney CFS asked all its practitioners to complete case summaries for all the children they were working with to capture what they knew so this could be saved in the interim case recording system - this was particularly important if practitioners were going on maternity leave or leaving the organisation, but was also vital to share and record known information in the absence of historic case records.

ASSURANCE

A suite of new forms were immediately put into use so that practitioners could continue to record their work from the first day of the cyberattack. The Council built an interim social care recording system so practitioners could continue to record and view their work with children and families - this went live for practitioners in January 2021. The Council also rebuilt its live performance reporting system (Qliksense) to provide live data to operational and strategic managers in the Children and Families Service to be able to track and monitor the progress of work with children and families.

ASSURANCE

ICT colleagues are continuing to work to recover information from historic case records from prior to the cyberattack. Previous case notes from before October 2020 were recovered and added to the interim social care recording system in March 2021. This supported practitioners to understand the history of families they were working with. ICT are continuing to work on recovering further historic information.

ASSURANCE

As a result of the cyberattack, NHS Cyber Security severed their connection to the NHS Spine which prevented Child Protection – Information System (CP-IS) uploads and downloads. CP-IS is a database that is used locally by Homerton Hospital to identify vulnerable children.

CP-IS Operations Team have been in regular contact with LB Hackney to offer assistance. With no case management system or database, LB Hackney and Homerton reverted to manual processes.

No new plans were being uploaded onto the NHS Spine and no attendances at unscheduled health settings were being sent to the LA.

Local processes for data sharing were set up with the main local NHS Trusts. Their mitigating child safeguarding processes have been audited and accepted.

NHS Digital extracted all LB Hackney data held on the spine and sent for audit.

Hackney Demographics

The London Borough of Hackney is an inner-city London borough. Its population is estimated at 281,100 people with 23% of its population aged under 18 (63,823 children). Hackney is a culturally diverse area, with significant 'Other White', Black and Turkish/Kurdish communities. A large Charedi Jewish community is concentrated in the North East of the borough and is growing. Hackney was the 22nd most deprived local authority overall in England in the 2019 Index of Multiple Deprivation, in 2015, it was ranked eleventh, and in 2010 it was ranked second. It is relatively more deprived in relation to barriers to housing and services. income and living environment than its overall rank suggests, but generally less deprived than its overall ranking for crime, employment and health and significantly less deprived for education. At GCSE the average Attainment 8 point score per pupil in Hackney was 49.2 points, slightly lower than the London average of 49.7. Crime fell by over a third between 2003 and 2015 (over 13,000 fewer victims of crime). Crime levels have increased by a third since 2015. Crime in Hackney is now higher than in other inner-London boroughs with similar social and economic characteristics.

Early Help

Children and young people in Hackney continue to have access to and benefit from an extremely wide range of early help services that are sharply focused on meeting the diverse needs of local communities. These services are delivered by the Hackney Children and Families Service, Hackney Education and a range of partners, including 74 schools, a network of 21 children centres delivering a range of services and working closely with schools, GPs and health colleagues as well as other local service providers, including the community and voluntary sector.

CHILDREN'S CENTRE FAMILY SUPPORT AND MULTI-AGENCY TEAM (MAT) MEETINGS

Family support in children's centres seeks to improve parenting capacity, protect children from harm and neglect and improve outcomes for young children. Family support is part of the early help Universal Partnership Plus offer to families with children predominantly but not exclusively, under 6 years and is coordinated by the MAT (Multi-Agency Team meetings), underpinned by the Common Assessment Framework (CAF) early help assessment. MAT meetings have continued to occur fortnightly in each of the six strategic Children's Centres in Hackney. Chaired by a qualified social worker employed by Hackney Learning Trust, MAT meetings are attended by a range of professionals including midwives, health visitors, Children's Centre family support teams, speech and language therapists and First Steps. Early help interventions delivered include: parenting programmes; individual and small group work to address family relationships and dynamics; support with: housing; finance; child behaviour; sleeping; toilet training; routines; and the transition to nursery and school.

IMPACT

Early help interventions are largely effective in meeting the needs of the children and young people who access them. Only 12% of MAT cases that closed in 2020/21 ended in escalation to statutory services and 72% (208) of MAT cases closed with a lower risk assessment than the preliminary risk assessment at the start of the intervention.

Of children whose allocation to Family Support Units ended over the past 6 months, 11% of these cases escalated to statutory services.

12% of the cases received for coordinated Early Help support from Multi-Agency Teams during 2020/21 were stepped down from social work intervention.

YOUNG HACKNEY

Young Hackney provides early help, prevention and diversion service for children and young people aged 6-19 years old and up to 25 years if the young person has a special education need or disability. The service works with young people to support their development and transition to adulthood by intervening early to address adolescent risk, develop pro-social behaviours and build resilience. The service offers outcome-focused, time-limited interventions through universal plus and targeted services designed to reduce or prevent problems from escalating or becoming entrenched and then requiring intervention by Children's Social Care.

NEIGHBOURHOOD PROGRAMME - CCG

Through the City and Hackney Neighbourhoods programme, the CCG has been progressing several projects that aim to strengthen knowledge and understanding of practitioners working within neighbourhoods and strengthen pathways through services. It has revised the processes of involving Primary Care in multi-agency discussions regarding 0-5 years children and their families so that GPs are better linked in. The CCG has also been testing the strengthening of links and pathways between services working with vulnerable adults and services for children and young people.

ASSURANCE

The CCG is progressing a project that aims to strengthen links between Primary Care and Schools with the aim that by the end of the next financial year, all Primary Schools will have a named contact at their Local GP Practices and there is a pathway for Schools to draw on expertise concerning children who are absent from School or who have specific, complex or chronic health needs. By the end of the academic year this should look like:

A named contact for Schools and their local GPs to have a direct line of communication to increase dialogue.

Clear pathways for managing health concerns within the school using GP advice.

A directory of GP contacts and named School contacts produced, so that with consent, respective parties can contact a child's GP to input into multi-agency discussions concerning children's wellbeing.

For children, young people and families this should mean health needs are being picked up earlier and families are being better supported through COVID anxieties to ensure children's absence from School is avoided or minimised.

Children in Need of Help and Protection

Good practice with children and young people who are in need of help and protection can be seen when help is provided early in the emergence of a problem and there is a well-coordinated multi-agency response. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Risk is effectively mitigated and outcomes improved through good assessment, authoritative practice, planning and review.

CONTACTS, REFERRALS AND ASSESSMENTS

During 2020/21, the First Access & Screening Team (FAST) acted as the single point of contact for referrals to Children's Social Care in Hackney and provided responsive screening activities.

EVIDENCE

FAST received 11473 contacts from a range of sources of which 2903 were accepted as a referral to CFS. This is a marked decrease in the number of referrals compared to 2019/20 (5031). The percentage of re-referrals increased from 15.8% to 18.6%. The reduction in volume mirrors that seen in other areas and is directly correlated to the pandemic and lockdowns resulting in children being less visible to the professional network.

The decrease in the rate of referrals in Hackney is also linked to a change in approach and methodology at the 'front door', including the introduction of a consultation line for professionals and improved early help pathways.

Following contact, the FAST aims to ensure that only those children meeting thresholds for statutory assessments are progressed as referrals to CFS. Local Authorities undertake these assessments to determine what services to provide and what action to take. The full set of statutory assessments under the Children Act 1989 can be found HERE.

EVIDENCE

3,664 assessments (574 per 10k) were completed in 2020/21, a 26% decrease compared to 4,923 assessments (771 per 10k) completed in 2019-20. Hackney's current rate of assessment is now far more in line with the rates seen in statistical neighbour authorities. The 2020/21 rate was slightly higher than the statistical neighbour 2020 rate of 547 per 10k and the 2020 national average of 554 per 10k. As with referral rates, the 2019-2020 statistical neighbour and national averages do not reflect the impact of the pandemic on the number of assessments completed, and it is expected that these averages will be lower for 2020-21 based on information about the decrease in referrals/assessments seen nationally during the pandemic.

EVIDENCE

Performance in relation to the timescale for the completion of assessments within 45 working days has continued to improve compared to previous performance against this indicator. 93% of assessments during the first quarter of 2021/22 were completed within 45 working days, compared with 77% in 2020/21 and 64% in 2019/20. A significant proportion of assessments result in families receiving a timely and proportionate response.

IMPACT

In February 2020 a review of FAST was undertaken, led by Hackney CFS, due to increasing levels of contact, referral and assessment rate and in turn a higher proportion of assessments that ended in No Further Action. The review wanted to understand if more children and families could be helped and supported at an earlier stage and how effective the application of threshold (need, harm and risk) was across the safeguarding partnership, but specifically to address how children and families could receive the right help and support that was proportional to their need, including the need for protection.

A Strategic Plan was put into place in May 2020, with a number of new initiatives rolled out over the year including:

A refresh of the Hackney Child Wellbeing Framework

The launch of a professional consultation line in February 2021

A representative from Hackney Education joining the multi-agency team in FAST.

Development of plans to transition the FAST into a Multi-Agency Safeguarding Hub (MASH)

ASSURANCE

There can be no doubt that partners have grasped the opportunities presented by the pandemic to bring operations closer together. Plans are in place to have a fully co-located and integrated MASH service, that will also harness a blended approach to partnership working.

STRATEGY DISCUSSIONS

Ofsted's inspection of Hackney's children's social care services in 2019 identified that in some strategy discussions, they do not involve all relevant partners sharing agency information until the initial child protection conference stage. In response, the CHSCP has developed this protocol as a practical guide for Hackney professionals involved in a child protection enquiry. It covers details about when strategy discussions should be convened, who needs to be involved and what factors need to be considered. The protocol includes an agenda template that will help you follow the process and understand the decisions that need to be made. This material has been further enhanced through the CHSCP launching an animated video guide on strategy discussions. Watch it HERE.

CHILDREN ON CHILD PROTECTION PLANS

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP).

EVIDENCE

308 children became subject to a Child Protection Plan in 2020-21, an 18% decrease from 374 children (59 per 10k) in 2019-20. The 2020/21 rate of 48 per 10k was higher than the 2020 statistical neighbour average (42 per 10k) and lower than the 2020 national average (55 per 10k). At the end of March 2021, 237 children were on a CP Plan. During the year, CP Plans were seen to increase. This was due to a reduction in the number of children ceasing to be subject to CP Plans in the first half of the year rather than an increase in the numbers becoming subject to CP Plans. The figures are indicative of the challenges that the pandemic restrictions presented in undertaking effective work with families to support them to reduce the level of risk to their children.

Children in Care

A child or young person who is in care is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances, Hackney CFS and partners will intervene because the child or young person is at risk of significant harm.

EVIDENCE

As of 31st March 2021, Hackney was responsible for looking after 426 children and young people There has been a significant decrease in the number of children who are in care from a peak of 477 children (75 per 10k) in November 2020, to 404 children (63 per 10k) in June 2021. This follows a sustained increase in the number per 10,000 during the first half of 2020/21. The June 2021 rate (63 per 10k) remains higher than the 2020 statistical neighbour average (61 per 10k) but is now lower than the 2020 national average (67 per 10k).

EVIDENCE

'Children in care and leaving care in Hackney benefit from a strong service.' OFSTED 2019

IMPACT

Prior to November 2020 there had been a particular increase in the number of 15–17-year-olds coming into care. Some of the increase in the number of children who are in care in 2020 was also due to Court proceedings being delayed due to the impact of the pandemic that meant that some children didn't move onto other arrangements.

The decrease in the number of children who are in care since November 2020 is linked to several factors including a focus on edge of care work to support young people where there is a risk of family breakdown as well as changes to the Children's Resource Panel. The Panel has been refreshed to offer a higher level of respectful challenge and high support, with a focus on mobilising resources to step in to a family and reduce harm keeping children at home where possible, enabling Hackney CFS to be more confident that it has the right children in its care.

PLACEMENT STABILITY, TYPE & LOCATION

On the whole, stability is associated with better outcomes for children. Proper assessment of a child's needs and a sufficient choice of placements to meet the varied and specific needs of different children are essential if appropriate stable placements are to be achieved. Inappropriate placements tend to break down and lead to frequent moves. Data capture on these indicators was affected by the pandemic. Similar to earlier years, the vast majority of children who are in care are in foster placements.

Care Leavers

The Leaving Care Service ensures that young people are supported to develop independent living skills, offered career advice and training and educational opportunities, and supported to reach their full potential in all aspects of their life.

Each year over 10,000 young people leave the care system and become care leavers. Their immediate transition to independence and the years that follow can be difficult for many. With little to no family support, the lived experience of some can be extremely challenging and isolating. In 2020, the CHSCP published a briefing paper building on our collective understanding of the challenges faced by care leavers. It provides several headline messages for improving multi-agency safeguarding practice. It summarises the lessons from the reviews of two cases involving care leavers who tragically died by suicide. Wherever you work, use this briefing paper to generate discussion about the vulnerability of care leavers, particularly in the context of their mental health. Talk about what you can do differently, reflect on the key messages and above all, ensure your individual practice is sufficiently attuned to them.

Violence Against Women and Girls

It is estimated that 3 in 10 women (aged 16+) will have experienced domestic abuse at some point in their lives and that 1 in 5 children have been exposed to domestic abuse in the home. Applying these figures to local populations would suggest that 34,142 women have experienced intimate violence, with 5804 children and young people being either directly or indirectly affected by it. Responding proactively and in collaboration with the Community Safety Partnership remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people.

The CHSCP is represented on Violence Against Women and Girls operational and strategic panels, which is comprised of statutory and voluntary sector organisations. The partnership in Hackney progressed its ambition to move from a strategy based on tackling DV to one that aims at a wider approach responding to all forms of VAWG. This development follows national and regional policy and aims to embrace all forms of violence that are committed against women and girls as they have a number of commonalities and therefore suggest a linked approach.

Operationally, the Domestic Abuse Intervention Service (DAIS) in Hackney encompasses the following areas:

- **Intervention Officers.** The Intervention Officer posts allow for the recruitment of social workers, former police officers, probation officers as well as qualified domestic abuse advocates. This will build a service with a mix of skills and backgrounds who are experienced in assessing and managing risk.
- **Perpetrator interventions.** This model integrates allows for the flexibility for staff to engage with perpetrators directly as needed to deliver a responsive, holistic and victim-focused risk management service.
- **Operational and strategic management.** Managers are responsible for operational case work and for strategic / partnership working. This differs from the usual model whereby a 'VAWG co-ordinator' role sits separately from the delivery of risk management services working with clients.

From April 2017, the Domestic Abuse Intervention Service (DAIS) joined the Children and Families Service as part of the Early Help and Prevention Service. DAIS works with anyone experiencing domestic abuse who is living in Hackney, aged 16 or over, of any sex and gender, and of any sexual orientation. The service assesses need; provides information and support on legal and housing rights; supports service users with court attendance; supports service users to obtain legal protection; and works with service users and other professionals to address their needs. The service also works with perpetrators of domestic abuse to try to reduce risk.

EVIDENCE

DAIS have throughout 2020-2021 managed capacity with a continued offer of in-person appointments either at the Hackney Service Centre, in homes or in other settings, telephone contact and virtual meetings. The Domestic Abuse Intervention Service received 1,354 new referrals between April 1st 2020 and March 31st 2021. The average weekly number of referrals across 2020/21 was 26, slightly above the weekly pre-Covid rate of 25 cases per week.

EVIDENCE

DAIS clients give positive feedback about DAIS. After DAIS' intervention, 76% of clients feel less likely to "have to change what I say or do based on how [the perpetrator] might react". 69% report feeling less worried about being hurt again. 88% reported that DAIS had considered well any issues relating to their identity. In terms of partner agency feedback on training provided by DAIS, 97.5% describe it positively with 72.5% describing training as 'very useful' with 97% reporting that their practice will be improved as a result of the training. 97% found DAIS to be an accessible service. 97% said if they had a friend or relative being hurt by someone they loved, they would recommend DAIS to them

MARAC

The number of cases considered at MARAC (multi-agency risk assessment case conference) continues to reflect a robust response to providing multi-agency support to victims and children at risk of domestic violence and abuse.

EVIDENCE

Numbers of high-risk cases have continued to rise during and following the covid restrictions. 2020/21 saw a total of 595 cases, an increase of 21% on the 492 cases heard in 2019/20. This rise in referrals was seen in other London boroughs and may be due to better recognition and reporting as well as a rise in actual high risk domestic abuse precipitated in part by covid restrictions providing greater opportunity for perpetrators to abuse and control victims. The MARAC has continued throughout and since the covid restrictions period to operate successfully. Police, the Council and partner agencies have found the online forum to be more efficient regarding multi-agency participation, sharing information before and during the meeting and agreeing joint actions to reduce harm. Of the total MARAC cases, 279 involved children in the household (an increase from 253 in 2019/20).

Safeguarding Adolescents

Understanding the context in which children and young people live their lives is an essential feature of effective multi-agency intervention. For the CHSCP, this issue remains central to our overall approach in making children and young people safer. Context is key. During 2019/20, the CHSCP refreshed its defined strategy for safeguarding adolescents. This strategy builds on the progress made by the partnership in safeguarding children and young people at risk of child sexual exploitation (CSE) and those missing from home, care and education. It was developed in parallel to our improved understanding of the issues facing young people; established through focused problem profiles, national and local learning and intelligence pictures involving vulnerable adolescents.

The strategy continues draws on evidence about effective practice from contemporary research. It is a focussed document that sets the parameters for developing our understanding of the complexities of young people's vulnerabilities and finding more effective multi-agency responses to these issues. The strategy maintains an unswerving focus on making sure that professionals are getting the basics right whilst striving to develop best practice in terms of the following priorities:

- Knowing our Problem, Knowing our Response
- Strong Leadership
- Prevention and Early Intervention
- Protection and Support
- Disruption and Prosecution

The partnership has continued to develop its understanding of exploitation and extra-familial harm including criminal exploitation, county lines and trafficking. The Extra-Familial Risk Panel, a key operational component, continued to be held fortnightly to ensure consistent oversight and planning for cases where young people are at risk of experiencing, or are involved in, harmful behaviours outside the home. There is strong multi agency attendance from Police, Education, Health, Youth Offending Team, Young Hackney and the Integrated Gangs Unit. The Panel develops operational actions which looks to reduce harm and disrupt exploitation of children. Themes and strategic issues from the Extra-Familial Risk Panel are shared with the Multi-Agency Child Exploitation (MACE) group for wider consideration and agency action. Both forums also report back any significant issues via the CHSCP Safeguarding Adolescents Group.

CHILD SEXUAL EXPLOITATION

Understanding the nature and prevalence of child sexual exploitation (CSE) and harmful sexual behaviour (HSB) and ensuring that partner agencies provide appropriate safeguarding responses and interventions remains a priority. In February 2017, a revised definition of CSE was issued by the Department for Education (DfE).

'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.'
DfE 2017

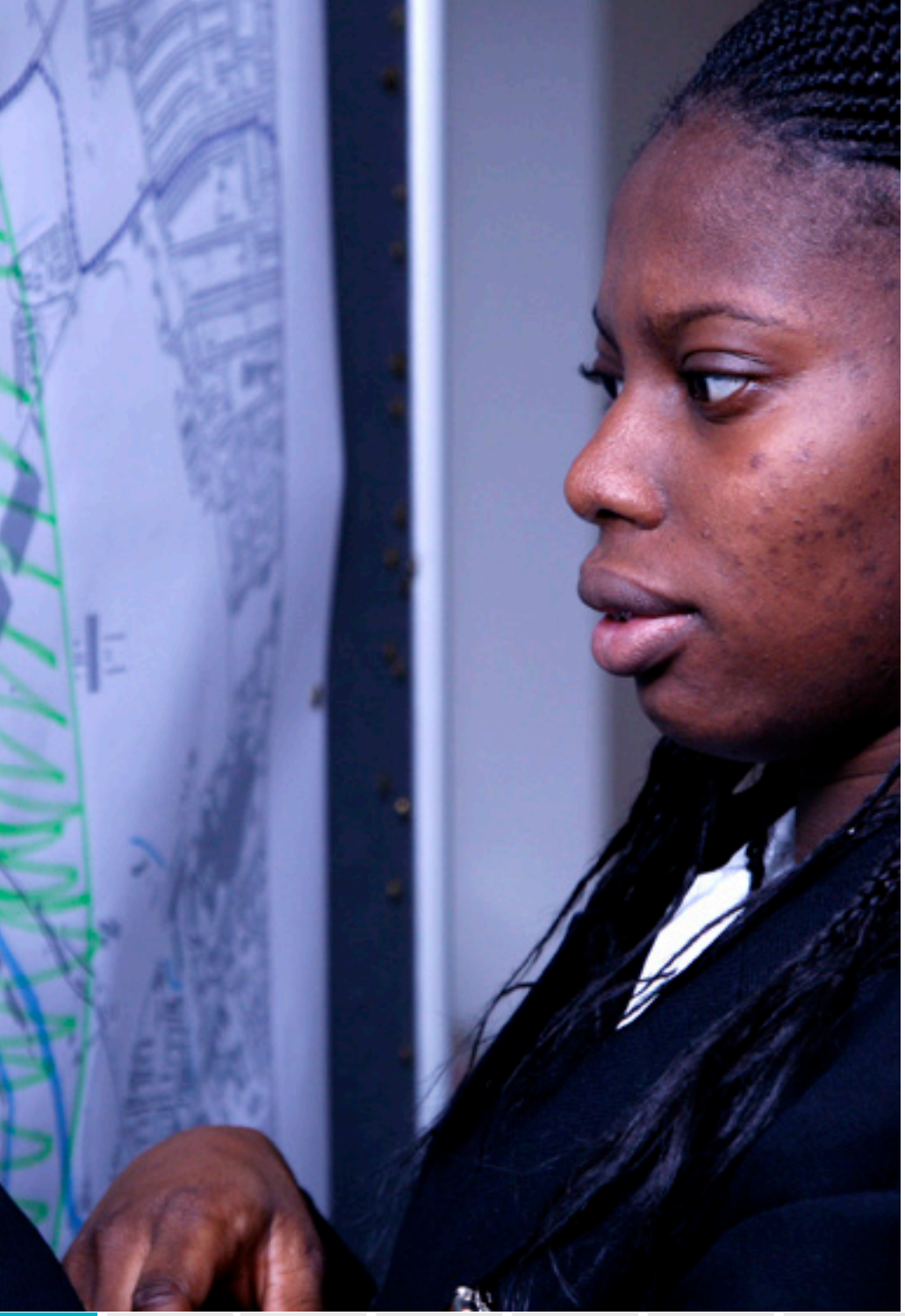
EVIDENCE

Analytical research has been undertaken to interrogate data relating to CSE and HSB and to identify emerging themes and trends which inform service development. The research has highlighted three broad CSE profiles in Hackney:

CSE risk resulting from peer-on-peer abuse (sexual offences/ exploitation against one or more victims and usually perpetrated in a group setting)

CSE risk from an adult perpetrator (typically a young person believing themselves to be in a 'relationship' with an adult after being introduced to them by a normally vulnerable friend, or through online contact)

Exploitation via social media (inciting or encouraging a victim to take and send explicit images of his/herself)



CHILDREN MISSING FROM HOME, CARE AND EDUCATION

The Police lead on all children who go missing from home or care and a coordinated response takes place with Hackney CFS working closely with the child's parents or carers. For those young people who repeatedly go missing this co-ordinated response often involves a lead professional from education, Young Hackney, Youth Justice Service and the Integrated Gangs Unit. Hackney CFS has led on strengthening the partnership's understanding of and response to children and young people who go missing from home and care. Missing episodes are considered as part of a broader spectrum of vulnerabilities affecting adolescents which include CSE, harmful sexual behaviour (HSB), radicalisation and gang and youth violence.

When a young person returns from an episode of going missing, they are offered an independent return home (IRH) interview by the Children's Rights Service. The use of Independent Return Home Interviews continues to be effective in supporting young people to share information about push and pull factors, what happens when they go missing and what support they need to reduce further episodes. The implementation of a daily meeting with Missing Police has supported better working relationships, information sharing and development of robust risk assessments and timely plans to locate children and offer the appropriate support. The most prominent themes in reasons children and young people have been going missing is 'difficulties at home or

school', with overcrowding being highlighted in a number of cases. Mental health was also a key precipitating factor for missing episodes, as was additional learning needs whereby young people became confused with how to get home or made poor decisions due to peer influences.

IMPACT

Hackney CFS and the police have agreed that any child identified as high risk with a pattern of missing episodes will have a Missing Child Meeting within 24 hours of them going missing rather than 72 hours, with the aim to respond to these children in line with other concerns, such as domestic abuse.

In respect of children missing education, The Children Missing Education (CME) Team continues to identify, monitor and track children missing or not receiving a suitable education. This includes liaison with FAST when there are safeguarding concerns. The work of the CME team fits closely with other strands of work to support vulnerable pupils including supporting schools and families to prevent poor school attendance, truancy, exclusions and supporting schools and families to get children back to school once absence has occurred. The team liaises closely with the Education Attendance and Admissions Services.

IMPACT

Over the last 18 months a rapid improvement plan in relation to Children Missing Education has been developed and implemented. This has included:

The development of a structure for a bi-annual teaching and a learning forum to support parents in securing positive outcomes for children and young people

The development and adoption of a protocol to set out our approach to engender improved relationships with the Orthodox Jewish community to establish whether or not children and young people are electively home educated.

The launch of an updated Elective Home Education (EHE) policy with schools in July 2020. A public campaign in November 2020 included settings within the Orthodox Jewish community.

The redesign of the Elective Home Education assessment framework in accordance with statutory guidance.

GANGS, EXPLOITATION AND SERIOUS YOUTH VIOLENCE

The approach of safeguarding partners to violence treats it as a preventable public health issue; using data and analysis to identify causes, to examine what works and to co-produce solutions. Incidents of serious violence have a significant and lasting impact on the wider community as well as for the young people and families involved. Safeguarding partners remain conscious of the impact and effect of trauma and as a partnership, we are committed to increasing resilience and developing trauma informed practice.

EVIDENCE

During 2020/21, local police and youth offending data showed a downturn in serious violence, however partners remained mindful of the increased threat of serious youth violence (SYV) as lockdown restrictions eased and young people returned to school. As of March 2021, police data for Hackney showed that knife injury for under 25's was down 35% compared to 2019/20. Total knife crime and robbery were both down 32%. The rate of SYV offences in Hackney indicates a downtrend and the borough is the only member of the 'YOT family' to experience falls each year. In Hackney male children continue to commit the majority of all SYV offences, although the total SYV offences by males has reduced. Common features of those engaged in SYV include complex and traumatic family experiences (domestic violence and/or abuse; SEND needs and experiences of school exclusion, family history of involvement in offending and parental substance misuse and/or mental health). In Hackney our education, health and social care services have placed emphasis on understanding these adverse childhood experiences and developing practice which is trauma informed.

Local police conduct serious violence threat assessments daily, weekly and monthly to support the tasking process. The tasking process ensures that partnership resources are allocated to undertake interventions in an integrated way. Health services and third sector charities are also playing a key part in the approach to tackling SYV. Red Thread and St. Giles Trust staff are embedded at Homerton University Hospital NHS Foundation Trust (HUHFT) and the Royal London Hospital trauma unit respectively and use 'teachable moments' to divert young people away from offending and violence. Hackney's Context Intervention Unit and Integrated Gangs Unit are developing closer working relationships with both teams to ensure the partnership is fully sighted on emerging trends

and peer groups and locations of harm. Within the Safer Schools Partnership, information is exchanged on a case by case or school by school basis to inform daily and weekly deployments of police, schools and partnership staff. A monthly Gangs Partnership Tasking Meeting is held to present the latest intelligence and analysis on gang youth related violence and exploitation. This meeting identifies priority areas and individuals who require immediate and longer-term partnership interventions.

EVIDENCE

Young Hackney Early Help & Prevention Service delivers the out of court function of youth justice. It offers young people aged 10-18 diversionary interventions whilst working in close partnership & collaboration with police, YOT, CSC colleagues and specialist services. Hackney's approach to prevention and diversion is to ensure that all young people offered an out of court disposal (Triage, Youth Caution, Youth Conditional Caution) are provided with interventions to reduce the risk of further offending.

Interventions focus on identity, building and creating opportunities for change through participation and community integration. Restorative justice, desistance & criminogenic factors and the Good Lives Model underpin interventions alongside an exploration of young people's own experiences of 'victimisation'.

Outcomes for young people offered an 'out of court disposal' are positive - consistently over the last 4 years Triage success rates (i.e. Not converted to First Time Entrant to the Youth Justice system) has been over 82%.

IMPACT

A Vulnerable Children's group was formed during the first lockdown and met fortnightly to monitor school attendance and consider the needs of vulnerable pupils. The group was attended by officers from Children's Social Care, Early Help and Education. Children and Families Service staff quickly identified young people in need of support, at risk of harm and in receipt of statutory or early help services through its casework database. An assertive approach was taken with young people, their families and schools to encourage and facilitate their return to in-person learning as a means of addressing their needs and reducing risk. Where they did not return to school, young people were engaged proactively in home and other settings e.g., parks and Youth Hubs.

IMPACT

In 2018 Hackney successfully bid to the Home Office's Trusted Relationships Fund to establish a detached outreach team with an embedded clinical psychologist. The team has operated throughout the pandemic and engages young people on the street to develop trusted relationships with professional adults, build resilience and reduce vulnerability to criminal or sexual exploitation. Delivery involves engagement through recreational sports and arts activities, support to develop critical thinking skills, information advice and guidance (substance misuse, relationships, health/ sexual health, careers), conflict resolution, safety mapping/ planning, first aid, mental health first aid, and sharps disposal. The project is subject to independent evaluation by the Behavioural Insights Team commissioned by the Home Office.

ADOLESCENT NEGLECT

Like younger children, adolescents are more likely to experience neglect at home than any other form of child harm. A report by the Children's Society into adolescents and neglect found that there was evidence that professionals struggle to identify adolescent neglect and are unsure what to do when they come across it. This has partly been based on misconceptions, including that adolescents become resilient to neglect and that neglect is less harmful than other forms of maltreatment. Neglect has been linked to a variety of problems for adolescents, including to 'challenging' behaviours e.g. poor engagement with education, violence and aggression, increased risk-taking (offending or anti-social behaviour, substance misuse, early sexual intercourse). It can lead to poor physical health, difficulties with relationships (with peers and adults) and be behind 'internalised' problems – e.g. low levels of well-being or mental ill health.

SELF-HARM & SUICIDE

The partnership's focus on self-harm and suicide continued over 2020/21 as a consequence of the deaths of a number of young people from Hackney. Learning from the published reviews into these cases is set out later in this report. This focus was heightened as a result of Covid-19 and the identified growth in demand for mental health provision for children and young people.

RADICALISATION

Statutory guidance expects Local Authorities to assess the threat of radicalisation in their areas and to take appropriate action. The Community Safety Partnership (CSP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard children and young people. The Prevent Strategy is a key part of the Government's counter-terrorism Contest strategy. It aims to stop people becoming terrorists or supporting terrorism and has three objectives - challenging ideology, supporting vulnerable individuals and working with sectors and institutions. A strategic priority for Hackney's Prevent work is to ensure the safeguarding of children and young people to prevent them becoming drawn into supporting terrorism. In Hackney a multi-agency Channel Panel, chaired by the Head of Safer Communities, works at the pre-criminal stage to support vulnerable individuals where a risk of radicalisation is assessed and a plan of action devised.

During 2020/21, there were 12 referrals to the Hackney Channel Panel (a decrease from 26 in 2019/20). 11 referrals concerned male subjects and one female. Four of these referrals involved young people under 18 generated from the education sector.

Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered.

Comparison with national and statistical neighbours has not been undertaken following the DfE ceasing to publish statistics on notifications and closing the private fostering data collection for local authorities.

A review of all private fostering arrangements was conducted in early 2020 and a new Private Fostering Policy was rolled out the following month. Numbers remained broadly in line with last year. As of 30 September 2020, only nine private fostering arrangements were open to Hackney. By July 2021, this had increased slightly to 12.

ASSURANCE

Bi annual audits of all Private Fostering are undertaken by Hackney CFS. These audits identified evidence of practice improvement. Of the audits in respect of the 12 children in private fostering arrangements in February 2021, 10 or 83% of cases were rated as 'good' or 'outstanding', and 2 or 16% were rated as 'requires improvement'. No cases were rated as 'inadequate'. The average score was 3 (good).

IMPACT

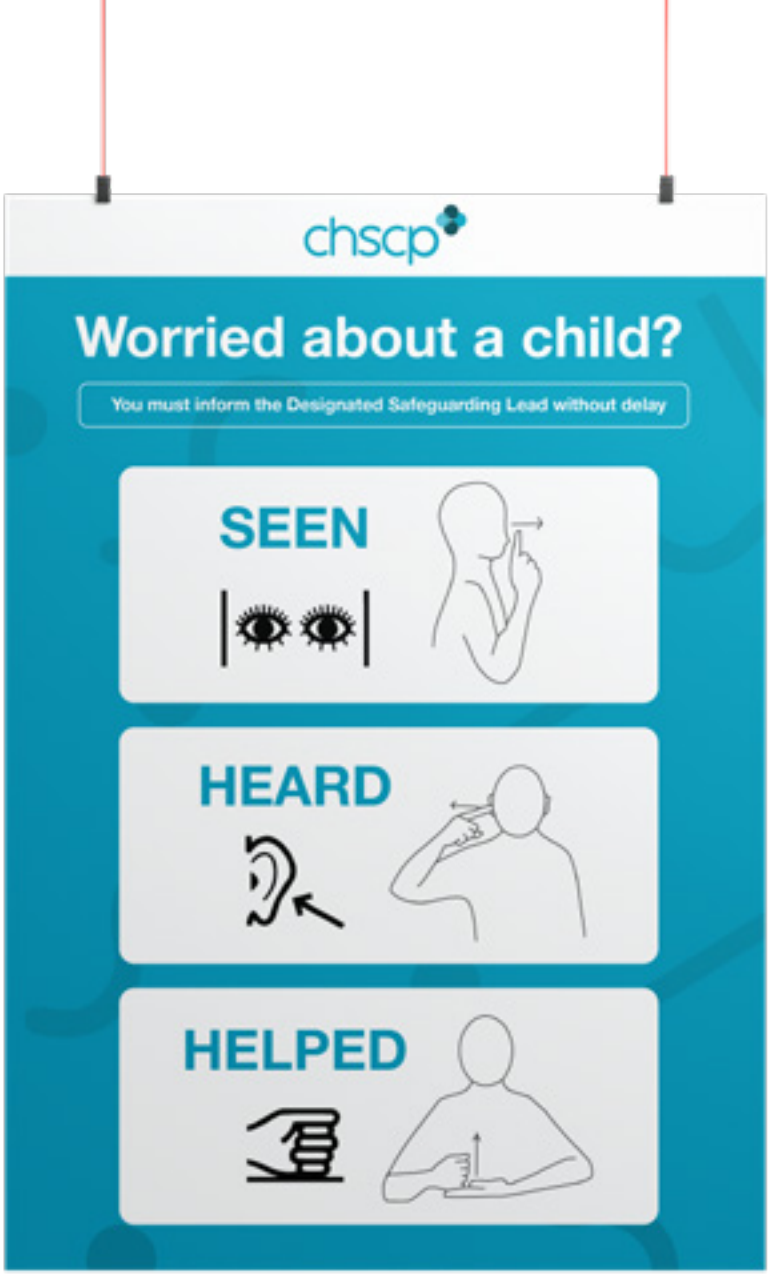
A Private Fostering App developed by the CHSCP to support awareness raising across the partnership has been downloaded nearly 7000 times. Hackney has worked closely with colleagues working on this area within the North London Consortium, to share best practice. They are also exploring opportunities to raise awareness with specific local partners, for example, looking at the admissions process with Hackney Education and local voluntary sector organisations about increasing understanding of the private fostering regulations within the Orthodox Jewish community.

Children with Disabilities

At the end of March 2020, the service was working with 402 children and young people. Of these, 267 were male and 132 were female (3 children were not yet born). This is an increase of 20% compared to 2018/19, when the service was working with 336 children and young people, In 2017/18, the service was working with 241 children and young people.

IMPACT

Following engagement with the Head of Safeguarding at Homerton Hospital and The Garden School in Hackney, the CHSCP produced an awareness raising poster in Makaton for promotion in settings where children have communication difficulties.



Children's Mental Health

The Child and Adolescent Mental Health Services (CAMHS) in City and Hackney are provide by Homerton University NHS Foundation Trust (First Steps and the CAMHS disability team, a joint service with the ELFT CAMHS); Clinicians employed by London Borough of Hackney's children's social care and the Specialist Service is provided by the East London NHS Foundation Trust (ELFT). ELFT CAMHS provides the specialist (Tier 3) community-based service, the CAMHS provision within the Young Hackney Service and a service for adolescents with more complex mental health needs, for example, first onset psychosis and complex eating disorders. East London NHS Foundation Trust also provides the inpatient service (Tier 4) and the out-of-hours service for City and Hackney.

EVIDENCE

Impacts of the pandemic have been seen with Tier 4 beds at capacity and increasing presentations. This continues to be addressed with a new crisis group working with the provider collaborative, an integrated discharge planning group meeting fortnightly to strengthen the community offer and several new services supporting families online. The CCG is also developing plans for an integrated T3 service.

EVIDENCE

Since the first Covid-19 lockdown in March 2020, there been a significant increase in the number of children and young people admitted to Homerton hospital in emotional distress. In the first 3 months of 2020/2021, there were 11 admissions of which eight young people were transferred to the Coborn adolescent psychiatric unit. This was a 73% increase compared to the same period last year. The trajectory of growth in respect of mental health continued over the rest of the year. Of significance, diagnosed eating disorders were identified as increasing significantly. The sufficiency of the partnership's effectiveness at meeting the mental health needs of children and young people remains a priority.

EVIDENCE

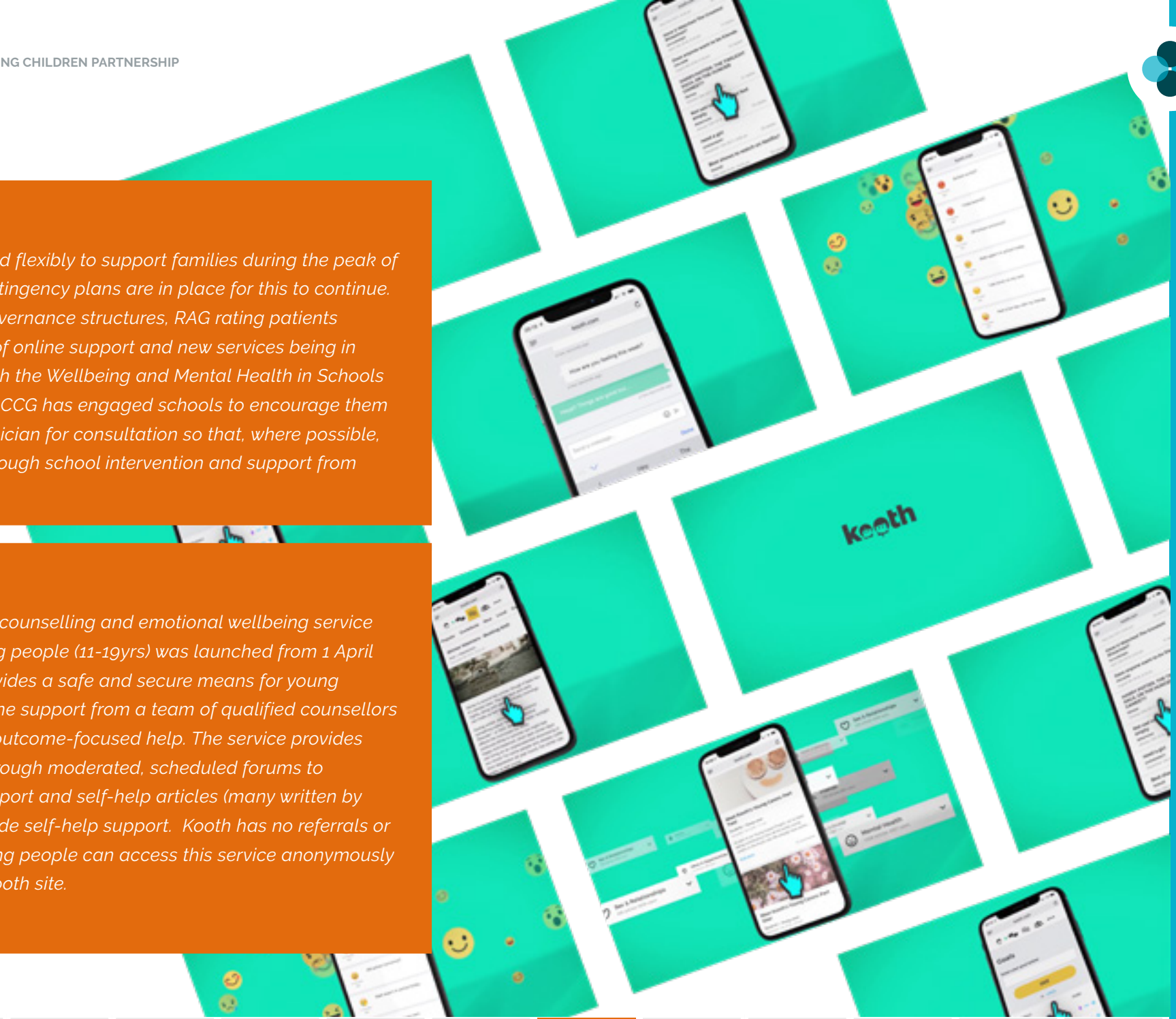
CAMHS did (and still does) a clinical rag rating of children who should be seen face to face for clinical reasons, but also prioritises children in terms of digital inclusion/digital poverty (i.e. those who can't connect or don't have access to privacy etc). Before schools re-opened, CAMHS were very aware that not all vulnerable children weren't being 'seen' in school or by other agencies as regularly and safeguarding was considered by CAMHS practitioners when contacting those families. The CAMHS risk assessment covers safeguarding, DV, exploitation and other safeguarding issues.

ASSURANCE

CAMHS has responded flexibly to support families during the peak of Covid-19. Robust contingency plans are in place for this to continue. This includes solid governance structures, RAG rating patients and the introduction of online support and new services being in development. Through the Wellbeing and Mental Health in Schools (WAMHS) project, the CCG has engaged schools to encourage them to use their linked clinician for consultation so that, where possible, cases can be held through school intervention and support from other agencies.

IMPACT

***Kooth** – A new online counselling and emotional wellbeing service for children and young people (11-19yrs) was launched from 1 April 2020. The service provides a safe and secure means for young people to access online support from a team of qualified counsellors who provide guided, outcome-focused help. The service provides additional support through moderated, scheduled forums to facilitate peer led support and self-help articles (many written by service users) to provide self-help support. Kooth has no referrals or waiting lists, and young people can access this service anonymously by signing onto the Kooth site.*



MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory measures for managing sexual and violent offenders. The Police, Prison and Probation Services (Responsible Authority) have the duty and responsibility to ensure MAPPA are established in their area and for the assessment and management of risk of all identified MAPPA offenders. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public from serious harm, by ensuring all agencies work together effectively.

MAPPA

Across London on 31 March 2021, there were 6549 Category 1 'Registered Sex Offenders' (RSOs) (6581 in 2019/20 and 6452 in 2018/19), 3521 Category 2 'Violent Offenders' (3735 in 2019/20 and 4128 in 2018/19) and 61 Category 3 'Other Dangerous Offenders' (31 in 2019/20 and 27 in 2018/19).

Unregistered Educational Settings

In the context of Hackney, the response to Unregistered Educational Settings (UES) has focused upon Yeshivas within the Charedi community. Many of these Yeshivas provide 'full-time' education to children of compulsory school age but teach a curriculum that is too narrow for the setting to constitute a 'school'.

The consequence is that they cannot be registered (or regulated) and this remains a significant issue of concern for the safeguarding partners of City & Hackney Safeguarding Children Partnership (CHSCP). Despite ongoing efforts to engage community leaders and lobby government for change, the situation remains largely unchanged.

That said, activity by the CHSCP and the Council has yielded several changes that have supported and improved the multi-agency architecture responding to this issue. This has been driven via four relevant and related work strands.

EVIDENCE

The continued engagement and efforts of the Independent Child Safeguarding Commissioner on behalf of the CHSCP.

The work and oversight of the UES Working Group, now chaired by the Director of Hackney Education.

The work of the Out of Schools Settings (OOSS) Project (led by Hackney Education as part of a DfE funded initiative to better engage OOSS in the child safeguarding agenda (note; this includes UES but is not solely limited in its focus to these settings).

The implementation of the UES protocol, which provides a multi-agency framework for coordinating the response to settings by bringing together a range of services and partners.

IMPACT

Strategy *- In response to the CYP Scrutiny Commission investigation on UES, a strategy was developed by Hackney Council, setting out its approach to tackling this issue. The impact of the strategy has been limited. The overall vision remains frustrated on a number of levels. Indeed, although the Council has endeavoured to constructively manage this problem, no real progress has been made. There are considered to be two primary reasons for this.*

The first reason is highlighted by the absence of a central faith and community based body with responsibility for and authority over yeshivas. Each setting is understood to be autonomous and the local proposals to strengthen safeguarding oversight have simply gained no traction. Whilst there remains an aspiration by partners to work together to ensure that all children in Hackney receive appropriate educational opportunities in safe and suitable environments, there is all but no progress in the context of collaboration and co-production in this regard.

The second reason is because there is no existing regulatory/statutory framework within which these settings neatly fit. As a consequence, the Council has been both required and encouraged to be lawfully audacious in its approach to assuring the safety of the children who attend these settings, which the Council has done with limited success.

The Council has engaged (and continues to engage) the police, fire service and other partners focusing on health and safety to intervene with those running the establishments in an effort to safeguard the young people frequenting them. The position the Council finds itself in was previously summarised by Amanda Spielman, Ofsted's Chief Inspector "We can issue a warning notice, but … .no one has the power to close them, neither us, local authorities or the Department for Education. There is no general power to close something that is not registered as a school. We need a better definition of a school – it is too easy to fiddle at the margins and claim that something isn't a school. When people are operating illegally, there should be somebody with powers to make it close. There should be serious consideration of disqualifying people who've run an illegal school. The legal framework needs to evolve."

IMPACT

Engagement *- Disappointingly, despite repeated attempts to engage community leaders and seek their cooperation to develop a safeguarding reassurance framework, they have been unable, unwilling or lacked the overarching authority to commit to the changes required. Significant communication has been sent by the Independent Child Safeguarding Commissioner of the CHSCP to a variety of stakeholders encouraging UES to engage in a range of opportunities set out within an agreed 'offer' (to be led by the CHSCP and Hackney Education).*

IMPACT

Evidence at IICSA *- The ICSC of the CHSCP has also given evidence on behalf of the Council to the Independent inquiry into Child Sexual Abuse (IICSA). This was as part of the Inquiry's focus on religious institutions and settings. This set out the already known problems, the attempts at resolution and the action required by the government. IICSA published its report in September 2020. Recommending that the government should introduce legislation to change the definition of full-time education, and to bring any setting that is the pupil's primary place of education within the scope of the definition of a registered educational setting; and provide the Office for Standards in Education, Children's Services and Skills (Ofsted) with sufficient powers to examine the quality of child protection when it undertakes inspections of suspected unregistered institutions.*

IMPACT

UES Protocol *- In 2020, the CHSCP developed a protocol to help manage the response to the identification of UES and any concerns arising in respect of them. It is disappointing that this has been necessary, but in the absence of any appetite from either community leaders or Yeshivas themselves to cooperate, this is the best we have been able to do as a partnership. UES protocol meetings are chaired by the Head of Wellbeing & Education Safeguarding, Hackney Education. When convened, there is good engagement from all relevant agencies, including Ofsted. The Disclosure & Barring Service has recently been made a standing member of the group. The protocol itself is relatively straightforward. There is an expectation that when UES are identified, they are notified to Hackney Education and when there are reported concerns, that defined procedures oversee the response to these. The protocol has not been constructed on the basis of educational registration requirements, but on core safeguarding requirements. It is already distinct in that its entire focus is upon those settings that are neither registered nor regulated.*

IMPACT

Lobbying *- The record on this issue already details the significant lobbying undertaken with ministers. Disappointingly, there appears to have been little appetite to progress solutions at pace and the overall response from the government has lacked any sense of urgency. The Department for Education launched a consultation concerning the regulation of UES and other independent settings on 14 February 2020. This consultation was withdrawn on 7 May 2020 due to the coronavirus (COVID-19) outbreak and was relaunched on 13 October 2020. It closed on 27 November 2020.*

More recently, the CHSCP's Independent Child Safeguarding Commissioner has escalated this matter to the former Parliamentary Under Secretary of State for the Schools System (Baroness Berridge of the Vale of Catmose). This yielded no clarity. Subsequent letters to the new Secretary of State for Education, The Rt Hon Nadhim Zahawi MP, were the same. The new Parliamentary Under Secretary of State for the Schools System, Baroness Barran, replied on 3 December 2021. Her letter stated:

> ***I am happy to confirm that the government remains committed to changing the law on the registration of independent education settings, which would bring into scope a range of currently unregistered institutions. You will know that we repeated that commitment in the department's evidence to the Independent Inquiry on Child Sexual Abuse, and we welcomed the recommendation when the report was recently published. I expect that we will be publishing the response to the Regulating Independent Educational Institutions consultation shortly.***

Our collective position remains unchanged. Government needs to strengthen both the registration requirements and regulation of UES. Without such change, children and young people will continue to be exposed to a two-tier safeguarding system that is simply unacceptable.

Out-of-School Settings

Many children and young people participate in some form of organised activity outside of school at some point during their primary and secondary school years. There is plenty of excellent local practice which provides a wide range of activities and opportunities to young people and the community, for example improving cultural awareness, building self-esteem and encouraging our children to be active citizens within their community. In Hackney, the Out Of School Settings (OOSS) project continued with the aim of helping parents and carers make sure that their children are happy, safe and protected in after school and extra-curricular activities. Led by Hackney Education, this DfE funded project intends to strengthen the safeguarding arrangements within Out of School Settings.

IMPACT

OOSS Activity *- The strategic direction of the OOSS project has been to build a comprehensive typology of settings and test interventions to discover what works and identify the challenges or barriers to engagement. In practical terms the interventions have included meetings with trustees, staff and volunteers, policy support and the offer or signposting to safeguarding training. The OOSS project team has undertaken extensive mapping of the sector and identified over 300 settings including yeshivas, tuition centres, sports clubs, housing associations, community centres, charities, church halls and other religious settings.*

The OOSS project team has also developed a RAG rating system. This has been adopted by other pilot projects and promoted, via the DfE, as a model of good practice. Engagement thus far has concentrated in community spaces, particularly those hiring halls to other/smaller organisations or clubs and ensuring hire agreements explicitly describe expectations to safeguard.

To support this, an example policy has been written and organisations are signposted to relevant sources of support including the NSPCC's webpages for the sector, the voluntary code for OOSS and CHSCP training.

A significant challenge to understanding and embedding effective safeguarding practice is staff and volunteers accessing appropriate safeguarding training. To remedy this the OOSS project team has developed a training offer that will be delivered free of charge either in settings (if there are sufficient staff) or via The Tomlinson Centre. This sits alongside the core training offered by the CHSCP. Three sessions have been held, to introduce the OOSS project to settings have been delivered, supported by HCVS.

Promotional materials have been produced for parents/carers and for proprietors; information is presented on the Local Offer and an OOSS App is in development. This is in addition to an OOSS online portal that contains instructive videos from the Safeguarding in Education Team and Re-Engagement Unit of Hackney Education, highlighting OOSS responsibilities with links to local and national guidance. Partnership working with other pilot areas including Redbridge, Manchester and Birmingham is online to develop the portal. In conjunction with the CHSCP all mapped OOSS were sent a tailored Safeguarding Self-Assessment audit tool. In total 85 organisations responded.

Positive, but there is still work to do in this regard.

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a designated safeguarding lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the designated officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. The LADO should always 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.

EVIDENCE

Activity *- There were 174 contacts to the LADO in 2020/21, a 44% decrease from 309 referrals in 2019/20. This was due to the Covid-19 pandemic where the lockdowns and school closures resulted in less professional contact with children and young people. This was particularly relevant to the education sector, given schools and nurseries are the dominant employment groups that generate referrals to the LADO service.*

EVIDENCE

Themes *- This period saw a change for previous reporting, where the highest number of contacts has consistently been physical harm. In 2020/2021, 'concerns in private life' accounted for 28% of the total concerns, whereas physical harm was the reason for 21% of the LADO contacts. 'Conduct' was the third highest category at 20%. This change is likely to have arisen due to the pandemic and with people spending more time at home. Concerns arising in someone's private life are relevant to who work in settings with children, especially if there is the potential for risk transferability.*

EVIDENCE

Themes *- Another key theme for the period of 2020/21 was the increased complexity of some of the cases. For example, one case required three review meetings following the initial ASV meeting due to the nature of the concerns. It is unclear why complexity has increased, although this is a theme that has been echoed by colleagues across London. Again, it could be indicative of the complexities brought on by societal changes as a result of the pandemic, although this is somewhat speculative.*

EVIDENCE

LADO Training & Awareness Raising *- The Hackney Education (HE) Safeguarding in Education Team runs an extensive training programme throughout the year including Safeguarding and Child Protection training for Hackney Education staff, Designated Safeguarding Leads for schools, colleges and early years, school and college staff, governors, early years and childminders. Their training covers safe practice and the procedures for dealing with allegations against adults who work with children and young people. They continue to run specific training dealing with managing allegations for managers in the early years and school sector, once every academic year for schools and twice for early years managers.*

IMPACT

There was improved engagement with the LADO due to the accessibility enabled by virtual working. The speed at which meetings could be convened was also enhanced without availability being affected by travel, distance and room availability.

ASSURANCE

Where complaints arise in respect of the conduct of the police, although a LADO investigation will not necessarily follow, it was previously agreed that the LADO will follow up to ensure that the complaint is being dealt with and that the police will share the outcome of their investigation. This provides reassurance that a) the matter had been investigated and b) an official outcome had been reached. The MPS Child Safeguarding Development Group attended two London LADO Network meetings to work in collaboration with the LADOs and refine a draft MPS LADO Engagement Protocol. This was unfortunately placed on hold due to the COVID-19 pandemic. The ICSC is following this up as there still remains a level of ambiguity concerning expectations and the interface with the LADO process and that of the Independent Office for Police Conduct.

ASSURANCE

Practice audits of LADO work are conducted every 6 months by the Service Manager and Practice Development Managers in the Safeguarding and Reviewing Service. These consistently find timely responses from the LADO Service, positive working relationships between the LADO and partner agencies, clear actions and outcomes being achieved. What routinely remains problematic is a lack of written referrals/information being received from referrers, and partners not providing updates of feedback from their internal investigations as requested by the LADO. This results in additional work for the LADO in terms of having to outline phone conversations in emails so that the network is clear on advice provided and actions expected, and in following up requesting updates.

Learning & Improvement

Reviews of Practice

Local Child Safeguarding Practice Reviews (reviews) are undertaken on 'serious child safeguarding cases' to learn lessons and improve the way in which local professionals and organisations work together to safeguard and promote the welfare of children. These reviews were previously known as Serious Case Reviews (SCRs) but were transitioned to this alternative model in July 2019. The detailed arrangements for how they are undertaken are set out in the CHSCP's local protocol HERE.

ASSURANCE

Since its inception, the Child Safeguarding Practice Review Panel has emphasised the responsibility of safeguarding partners to decide upon whether a review is needed or not. However, the risks in this approach have been recognised, with safeguarding partners agreeing to maintain fundamental independence within the CHSCP's reviewing arrangements. This is the right thing to do in terms of transparency and to ensure that safeguarding partners avoid being in a position of 'either marking their own homework or deciding not to do their homework at all'. Locally, the decision-making function for reviews is delegated to the Independent Child Safeguarding Commissioner. Safeguarding partners ratify any decisions made, with a resolution process existing to deal with any differences of opinion.

EVIDENCE

There were three serious incident notifications and three Rapid Reviews submitted to the Child Safeguarding Practice Review Panel.

Two Local Child Safeguarding Practice Reviews were commissioned.

Four other cases were also considered by the Case Review Sub-Group, although none resulted in a local review.

Two legacy Serious Case Reviews and one 'Lessons for Practice' briefing were published.

Full details of all the reviews published by the CHSCP are available HERE.

Rapid Reviews

On notification of a serious incident, a Rapid Review meeting will be convened. The CHSCP has 15 working days from the original notification to produce and send an overview of the Rapid Review to the Child Safeguarding Practice Review Panel setting out the actions it intends to take. The panel will decide if the case is of national importance and may instigate its own review. During 2020-21, three Rapid Reviews were convened in 2020-21.

RAPID REVIEW 1 – CHILD R

On arrival at the family's address, paramedics from the London Ambulance Service found Child R to be unconscious with extensive physical injuries. He had bruising, lacerations, scabbing to his cheek, a large cut on his back and scarring around the feet. The accommodation was unkempt and there were signs of disturbance.

Paramedics contacted the Metropolitan Police Service. Child R was taken to hospital, where further tests identified a bleed on his brain. No explanation was given to the police to account for Child R's condition or his injuries.

Child R's mother maintained she had not seen anything and that her son was with her partner prior to the ambulance being called. A witness reported hearing shouting and sounds of a child being hit. Child R and his mother had only recently moved to Hackney and were living in temporary accommodation. Risks relating to domestic abuse and concerns about mother's parenting capacity were evident in the family history. In the days immediately preceding the discovery of Child R's injuries, reports were made to the police about his safety.

LEARNING

A review was initiated by the CHSCP and will be published on 2021-22. Potential improvements to safeguard and promote the welfare of children in this case relate to the effectiveness of what might be seen to be basic steps in respect of child protection practice. The professional response to concerns of child abuse, the thoroughness of questioning and investigation and the focus on the child are all relevant lines of enquiry.

Local police have now instigated a procedure whereby the body worn cameras of officers are dip sampled as part of a supervision and reassurance process.

RAPID REVIEW 2

The London Ambulance Service received a call for a child not breathing. Two paramedic ambulances were dispatched and arrived at the family home within ten minutes. The first resource on scene arrived in four and a half minutes.

The child was located by paramedics lying in an external corridor, with a neighbour administering CPR. Paramedics took over the active resuscitation and several life support drugs were administered. The child was placed on a ventilator and transferred to hospital.

Mother told paramedics that she had found her son hanging behind a door in the property. He was on his knees with a bicycle cable wrapped around his neck. He was unconscious, not breathing and unresponsive. Mother released the lock and took him out to the front of the property where neighbours assisted, and LAS was called. The child suffered a serious brain injury and sadly died.

LEARNING

The immediate response by practitioners to this tragic case was both sensitive and effective, with the family GP being identified as the single point of contact to provide and coordinate support to the family and surviving siblings. Neither abuse nor neglect were identified as contributory factors and no practice issues, recurrent themes or concerns about multi-agency working were identified. The criteria for commissioning a review were not met. However, following contact from the Designated Doctor for Child Deaths, the ICSC has escalated this case (and that of another family where a child accidentally died) to Hackney's Housing Services. The families continue to reside in the same accommodation where their children died in exceptional and traumatic circumstances. The two cases were discussed by the CHSCP's Strategic Leadership Team and whilst understanding the exceptional pressures on housing services, two issues have been raised for support and action:

That the Local Authority, in partnership with other agencies as appropriate, recognise these exceptional circumstances as requiring a 'safeguarding response' and that the families' moves to alternative accommodation are expedited.

For both the City of London and Hackney, that relevant housing protocols for moving families are reviewed and where required, amended to ensure they sufficiently prioritise circumstances that deal with the potential mental health impact on children and their families when children die at home (in such traumatic and exceptional cases.

RAPID REVIEW 3 – CHILD Q

This case focuses on examining the circumstances surrounding a search undertaken by the police on a young person whilst on school premises. The young person was observed by teaching staff to smell strongly of cannabis upon arrival at school. Given the circumstances of this case, a Rapid Review was initiated, and a report submitted to the Child Safeguarding Practice Review Panel. The Panel responded encouraging the CHSCP *'to think carefully about whether one [a review] is necessary as we felt that this case was not notifiable and did not meet the criteria for an LCSPR.'* Despite the Panel's suggestions, a review was nonetheless initiated. The relevant guidance set out in Chapter 4 paragraph 15-19 of Working Together to Safeguard Children 2018 was fully considered. The delegated and independent decision of the ICSC to commence a review was fully supported by safeguarding partners. Whilst acknowledging that the circumstances did not meet the precise definition of a 'serious child safeguarding case', there were unambiguous issues of importance in respect of local safeguarding practice. Potential improvements to safeguard and promote the welfare of children centre on three key issues.

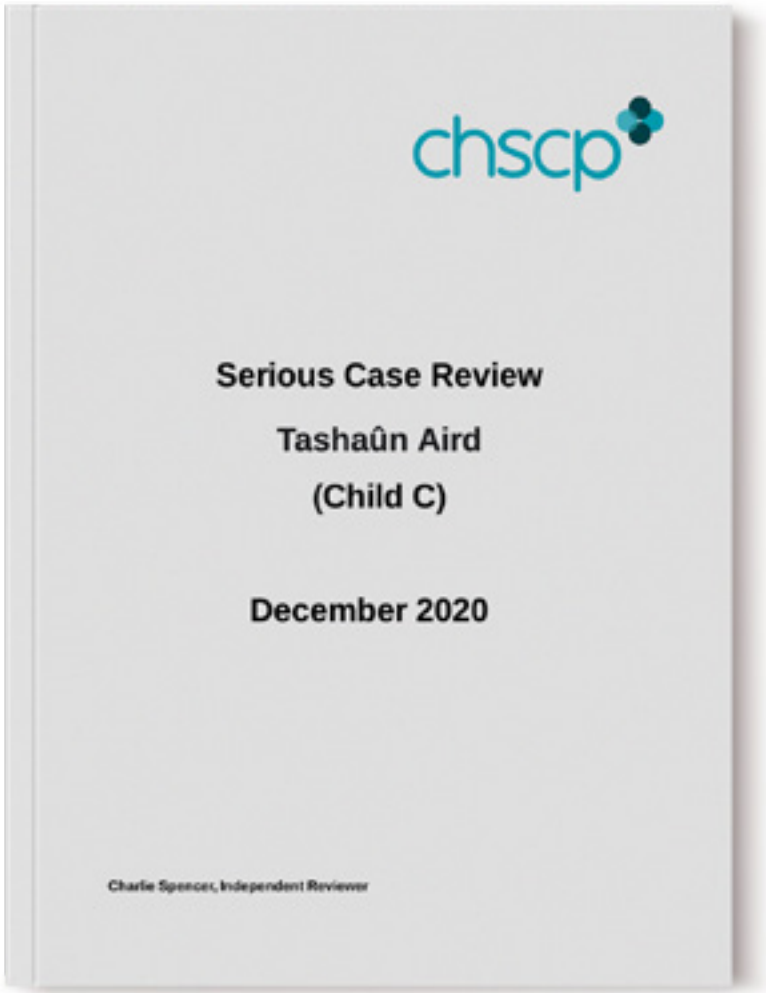
- Practice in such circumstances needing to be sufficiently attuned to the rights of children as set out in the relevant articles of the United Nations Convention on the Rights of the Child.
- Practice being sufficiently focused on the potential safeguarding needs of children, as opposed to a sole focus on criminal justice.
- Whether the law and policy, which informs local practice, is properly defined in the context of identifying potential risk and furthermore, that law and policy does not create the conditions whereby practice itself can criminalise and cause significant harm to children.

LEARNING

Adultification *- Recognising the need to immediately influence practice, the CHSCP commissioned a 12-month programme of training sessions on Adultification. Initially delivered to senior leaders across the safeguarding partnership, this training covers the broad concepts of racism, intersectionality and adultification, helping practitioners understand notions of vulnerability and childhood and how these are applied to some children more than others.*

IMPACT

Anti-Racist Practice *- The CHSCP has included Anti-Racist practice as one of its key principles governing our local arrangements. Alongside the significant single agency activity seen in this respect, work is progressing in the development of a multi-agency Anti-Racist charter and how we can better learn and improve practice in this context.*



Published Reviews

As of 31 March 2021, the following case reviews had been published by the CHSCP.

SERIOUS CASE REVIEW – TASHAÛN (CHILD C)

On 1 May 2019, Tashaûn Aird, a 15-year-old male, died after being stabbed whilst in the street. Tashaûn had been permanently excluded from school and three months before his death, he was seriously injured in another stabbing incident. On 19 December 2019, a 15-year-old boy was found guilty of his murder at the Old Bailey. A 16-year-old boy and an 18-year-old male were both convicted of manslaughter. A fourth suspect, a boy aged 16, died in custody prior to trial after becoming unwell. Tashaûn's Serious Case Review (SCR) was published in December 2020 and made nine findings relating to the protection of young people at risk of extra-familial harm.

LEARNING

- *Exclusion from mainstream school can heighten risk.*
- *Education settings need access to local intelligence.*
- *A focus on the individual child is important.*
- *Clarity is needed about interventions to mitigate extra-familial risk.*
- *Developing positive relationships with young people is important.*
- *Involving and supporting parents is essential to effective safety planning.*
- *Inconsistent judgements about risk creates uncertainty.*
- *The use of child protection procedures.*
- *Poor case recording can directly impact on practice.*

The SCR identified that a range of practitioners had access to information indicating that risk had escalated. They knew Tashaûn had been excluded from school, that he was frequently going missing, and intelligence suggested he was being criminally exploited. However, despite these signs, multi-agency practice lacked a collective focus on Tashaûn's lived experience and whilst it can be said that local procedures were broadly followed, they were insufficient to keep him safe.

The SCR action plan is overseen by the CHSCP Case Review Subgroup. The wider partnership response to extra-familial risk remains under the governance of the Safeguarding Adolescents Subgroup, although there remain close links with activity being delivered by the Community Safety Partnership. Progress against the plan has been broadly positive and several of the themes identified by the SCR have gained significant traction within our safeguarding system. That said, there remain stubborn challenges.

A full update of the action plan is available HERE. Key headlines are set out below.

IMPACT

Awareness Raising and Training *- Actions in response to the need for awareness raising and the delivery of training have largely been completed. Relevant learning continues to be promoted, embedded, and tested as part of the CHSCP's Learning & Improvement Framework. The SCR report has been cascaded to front-line practitioners via partner agency leads, single agency communications, a CHSCP Things You Should Know (TUSK) briefing and via the CHSCP website.*

Two learning seminars were also hosted by the CHSCP in March 2021. Led by the independent author, these sessions involved Tashaûn's mother, stepfather and sister providing an account of the family's perspective. Feedback was overwhelmingly positive, and the contribution of Tashaûn's family was powerful in driving home key lessons for practice. Over the course of the two events, 133 practitioners participated. 94% of those attending said the content was either excellent or very good and 92% said the learning shared on the day would enable them to safeguard children and young people more effectively. A selection of comments made by participants are set out below:

"The fact that the parents and sister of the young man who lost his life contributed to the presentation, was both humbling and powerful. I am most grateful to them for sharing their thoughts, feelings, and reflections. As professionals we MUST learn from this".

"The voice of the parents was crucial to us as professionals remembering we are dealing with people, not cases, and each child should be seen as an individual not a statistic".

"Understanding the true impact on the family. Having the opportunity to hear first-hand from the parents' perspective. Hearing real, live emotion, distrust, their journey. How things can improve from young people and the necessary steps to prevent this from happening in the future".

In support of these events and to help create a 'learning legacy' of Tashaûn's experiences, the family has also agreed to participate in a video training resource for the CHSCP. Whilst the imposition of the pandemic has frustrated our ability to finalise this, we remain hopeful it will be completed and launched in early 2022. This resource will be available to the entire professional network and will form part of the CHSCP training programme focused on safeguarding adolescents. Of relevance, Hackney Education has also revised the content of exclusion training for school governors to include reference to Tashaûn and the SCR's findings. Further information for school governors was similarly developed and has been shared via the Hackney Governors' Forum.

IMPACT

Exclusions *- The publication of Tashaûn's SCR has acted as a major catalyst for considering how schools are supported to prevent exclusions. Building on the work that has been already undertaken, proposals have been developed to create a universal education early help offer to support pupils vulnerable to exclusion. The Re-engagement Unit will be expanded to cover all primary schools and have an expanded offer for secondary schools, enabling them to support greater numbers of pupils who are vulnerable to exclusion than currently. This is being developed alongside the wider changes in early help provision within Hackney and it is envisaged that referrals for support would be made via the Early Help Hub, thus allowing for a wider understanding of needs and support to be established at the point of referral. The development of a universal education early help offer will enable greater numbers of pupils to sustain their placements in mainstream schools and reduce the need for Alternative Provision placements. These proposals are due to be implemented in September 2022.*

Alongside these proposals, the agreement with New Regent's College is due for renewal and will be updated to reflect the service required from New Regent's College going forward. Whilst recognising there will remain a need for some provision for pupils who have been PEX from school, the new agreement will consider how placements at the PRU and other AP settings can better support school inclusion in Hackney. The new agreement will commence in September 2022.

Whilst these plans are still in development, there has also been several immediate actions to improve information sharing and understanding of risk at the point of PEX. In order to improve the process, the exclusion notification form has been redesigned to include a short risk assignment that highlights to an AP any known risks. In addition details of all permanent exclusions are now routinely shared with MASH, YOT and Young Hackney so any existing information about the young person from those services can be shared with the AP prior to their starting. This means that when pupils start in their AP setting, there is a better understanding of who is working with the young person and any risks or issues that might affect their placement.

IMPACT

Alternative Provision *- A defined risk assessment process has been incorporated into the exclusion notification form. This will undoubtedly support Alternative Providers as part of inducting pupils into a new setting and risk management in the context of the child, other pupils, peer groups and the setting itself. This was a key issue in Tashaûn's SCR, where the Alternative Provider held limited information about the risks that Tashaûn was exposed to.*

Engagement with Hackney's Integrated Gangs Unit is also progressing and a suitably anonymised briefing on the key themes, patterns and trends relating to gang activity will be produced for direct circulation to schools, colleges, the PRU and APs. The CHSCP remains committed to exploring with schools how the exclusions process can better accrue the benefits of multi-agency working. This will have the aim of leveraging support and mitigating risk.

IMPACT

Named Profesionals / Trusted Adults *- Tâshaun's SCR recommended that the multi-agency partnership should nominate a named professional or adult who has (or who can develop) a trusted relationship with children who are assessed to be of risk of serious youth violence. This named professional should focus on developing the child to adult relationship. Actions against this recommendation are complete.*

The CHSCP has revised and updated its practice guidance on strategy discussions to ensure that every child at risk of serious youth violence now has the possibility to benefit from developing a positive relationship with a trusted professional. Guidance now sets a clear expectation for trusted adults to be identified at the strategy discussion stage of intervention.

Multi-agency audits undertaken by the CHSCP in June 2021 identified evidence of good practice in this context with named / trusted leads identified in several cases involving serious youth violence. Strategy discussion guidance and its accompanying agenda template continue to be promoted by the CHSCP. A video explainer has also been released by the CHSCP and can be found here.

IMPACT

Risk Gradings *- The SCR recommended that the CHSCP should review partnership and individual agency processes that involve the application of risk gradings for young people at risk of serious youth violence. Where required, these should be changed to ensure consistency and a clear understanding as to what the judgement means in the context of practice. Actions in response to this recommendation are complete.*

Several multi-agency sessions were held to better understand practice in this context. It was agreed impractical to try and align all agencies' risk processes into one singular approach. This was largely due to the fact these are used for different purposes. As a 'workaround', local guidance has been strengthened to ensure that more detailed information about risk gradings / judgements is shared during strategy discussions (see below). The potential / relevance for this narrative to feature in other partnership meetings is being reviewed by Hackney CFS.

If in place within their agency (normally applicable to Police/Probation/ IGU), professionals need to share a RISK GRADING/CATEGORY assigned to the child (ren), explain the action taken/ to be taken as a result of this grading/category and share the date this will be reviewed (note: risk gradings/categories should always be updated when new and relevant.

SERIOUS CASE REVIEW - CHILD A

This complex Serious Case Review (SCR) covered the period from Child A's birth to the age of 11. It was initiated due to concerns about the amount of Fentanyl (an opioid) prescribed to Child A for pain management, suspected Fabricated or Induced Illnesses (which was investigated and unsubstantiated), how agencies had worked together, and the overall care provided to Child A. The SCR made the following findings:

IMPACT

Practitioners did not consistently listen to the voice of Child A so as to understand Child A's perspective, concerns and feelings in order to undertake a meaningful assessment. This was a feature across agencies. Child A's voice was strikingly absent from records.

Some of Child A's reported symptoms were responded to without any objective assessment by health professionals. This led to unnecessary and inappropriate medical intervention. FII was investigated as part of a child protection enquiry when Child A was ten years old, but unsubstantiated. The SCR sets out a basis for reframing existing guidance concerning the management of suspected FII and "perplexing presentations'.

There was an absence of a lead professional to co-ordinate and communicate the input of different agencies. This risked diagnosis and treatment being based on inadequate information and inappropriately left Child A's parents with the responsibility to pass communications and information between practitioners.

The absence of a local chronic pain team contributed to the inadequate monitoring and supervision of Child A's long-term medication. Following a period of hospitalisation, Child A was discharged on the analgesic Fentanyl. Over a period of six years, no professional was overseeing Child A's pain management or the impact of long-term opioid use.

There were weaknesses in practice to monitor the repeated postponement or cancellation of Child A's health appointments by the parents. Despite practitioners identifying concerns in this respect, there is little evidence that these were raised in supervision, effectively responded to or that local policy was followed.

There was an insufficient response in meeting Child A's educational needs. Child A became 'lost' in the system and there were no reviews held on Child A's educational progress for four years.

Practitioners insufficiently challenged and escalated their concerns about Child A. The review identified many examples when practitioners should have escalated their concerns and been more critically challenging of decisions made by others that impacted on Child A's safety and wellbeing. It was not until Child A was ten years old that a referral was made to Children's Social Care.

IMPACT

Practice Guidance *- Local Guidance on Safeguarding Disabled Children was refreshed and disseminated to ensure sufficient focus on defining the circumstances when children should be seen alone. The Guidance clarifies* ***"Where there is a safeguarding concern related to the child's home environment, the child should be seen away from their parents, outside of the home, with a professional (e.g. their teacher or a speech and language therapist) who is familiar with their preferred communication method. For disabled children subject to CIN or CP Plans, these arrangements should be made on an ongoing basis and at a minimum of every 8 weeks for CP cases and 3 months for CIN cases."***

Procedures *- Escalation to the London Safeguarding Children Partnership Chair requesting a review of pan-London practice guidance on Fabricated and Induced illness to ensure it appropriately takes account of children who are coming to harm through excessive medical intervention and references the revised policy of the RCPCH on perplexing presentations. The revisions and reference to the RCPCH policy have been included in the London Child Protection Procedures as of September 2021.*

Assessment of Needs *- Significant changes to the Wheelchair Service pathway are underway in response to this SCR including structured triage of referrals, clinical peer review, development of a shared pathway with the Physio pathway and documenting the voice of the child on the assessment form. An audit of cases is also underway to provide assurance around the new requirements.*

Continual Professional Development *- A Protected Learning Time event was facilitated by the NEL CCG (C&H) safeguarding team, C&H prescribing team and Great Ormond Street Hospital pain clinic. This event delivered to GPs, Community Pharmacists, the Clinical Lead for Pain Management, and Consultant in Paediatric Anaesthesia and Pain was designed to support knowledge and understanding around the prescribing and dispensing of opioids for children and enable effective challenge when children are prescribed medication outside of the normal parameters.*

Competency Framework *- The CCG reviewed and disseminated an updated competency framework (cross referenced against Working Together 2018, Intercollegiate Guidance and the GP Safeguarding Toolkit) to support GP Safeguarding Leads providing children and young people a safeguarding service that is safe, up to date and timely. An updated guidance / escalation chart (including reference to the MASH consultation line) has been issued to GP Safeguarding Leads to support the early recognition of a child at risk and escalation to children's social care.*

LOCAL REVIEW - CARE LEAVERS

Each year over 10,000 young people leave the care system and become care leavers. Their immediate transition to independence and the years that follow can be difficult for many. With little to no family support, the lived experience of some can be extremely challenging and isolating. This short briefing paper builds on our collective understanding of the challenges faced by care leavers and provides a number of headline messages for improving multi-agency safeguarding practice. It summarises the lessons from the reviews of two cases involving care leavers who tragically died by suicide. Wherever you work, use this briefing paper to generate discussion about the vulnerability of care leavers; particularly in the context of their mental health. Talk about what you can do differently, reflect on the key messages and above all, ensure your individual practice is sufficiently attuned to them.

IMPACT

Whilst recognising the need to balance issues relating to capacity and an individual's right to make their own choices, practitioners should always take a Safeguarding First approach when engaging care leavers.

Engagement of practitioners with the right skills to meet the needs of care leavers is essential to effective pathway planning. Such planning should always include a focus on mental health and local areas should ensure that services in this regard are sufficient to meet need.

It can be easy for young people to hide vulnerabilities. Practitioners should always hold in mind that some young people, including care leavers, will tell you what they think you want to hear. The reasons for this can be wide ranging and complex. They may relate to fear of what might happen if the young person 'opens up' or they may be an active intent to deflect concerns.

The immediate time period following a mental health crisis is a critical window of opportunity for both observation and support. Whilst a comprehensive safety and discharge plan is important for children and young people who have a family unit around them, it is also essential for those vulnerable young adults who live independently.

There is a need to consider the number of changes, transitions and the ending of relationships (both professional and personal) in a young person's life. The impact of such cumulative loss on outcomes should never be underestimated and is especially important for young people who have difficulty, or who take longer, to develop trusting relationships.

IMPACT

Transitional Safeguarding & the Child Protection Information System *- This review identified that once a young person becomes a Care Leaver, details are removed from the Child Protection Information System (CP-IS) alert system used by Health. Professionals may not, therefore, be aware of historic / current vulnerabilities when a Care Leaver attends a health setting. The CHSCP escalated this to the lead for CP-IS. A response confirmed plans to expand the system to include vulnerable adults, such as Care Leavers (who will have consented to their details being included) and expressing local support towards addressing the issue of 'transitional safeguarding', where we know vulnerabilities remain for young adults who turn 18.*

Previous Reviews

MULTI-AGENCY CASE REVIEW – CHILD E 2014

This review was initiated following a professional's visit to Child E's home that identified significant concerns regarding neglect. Questions were raised about the opportunities for earlier identification of the environment in which Child E was living; with an independent review subsequently being agreed by the Independent Chair. The following summary sets out the key areas of learning identified, some of the specific actions undertaken by the CHSCB and a range of examples of the impact that this review has had on the safeguarding system.

LEARNING

- *Children need to be seen, heard and helped, the importance of home visits and escalating concerns*
- *The importance of identifying and dealing with neglect*
- *The need for all staff to "Think Family"*
- *The importance and clarity of information sharing*

SERIOUS CASE REVIEW – FC 2015

In 2015, the CHSCB published a Serious Case Review (SCR) in respect of Case FC. The review involved a Hackney foster carer who, prior to his recruitment, was anonymously reported to the police about his use of indecent images of children. The police failed to investigate this complaint properly at the time and although information was retained about the anonymous report, it was never disclosed to Hackney Council. Over thirty children were subsequently placed by Hackney Council with this foster carer. In 2014, he received a custodial sentence after being found guilty of rape and a range of other sexual offences. Some of the victims were children in care. He is known to have sexually abused five children of primary school age, one victim in the community and one other unidentified victim abused some 30 years earlier. The SCR found that despite the police knowing about the initial allegation, on each of the occasions when the foster carer was subject to the regular criminal record checks that carers are required to undergo, a decision was made not to share that information with Hackney Council. At no time was Hackney Council given the opportunity to make an informed decision about the foster carer's employment. He escaped this scrutiny due to repeated professional judgements being made by the police on the basis of a particular understanding of legislation and case law regarding the sharing of 'soft intelligence'.

LEARNING

- *The weaknesses in the guidance relating to the disclosure of 'soft intelligence' under the Police Act 1997*
- *The need for GP contracting of counselling services to be clear about how to handle a disclosure*
- *An explicit recognition that children who are in public care need to be kept safe*
- *Educational work with children and young people to reduce the likelihood of further sexual abuse*

MULTI-AGENCY CASE REVIEW – CASE K 2015

In September 2013 (when they were aged 8 and 2) the police removed both children from their family home because of the extremely poor home conditions. It is now known, prior to this intervention, the family home had not been visited by any professional since late 2008. Both children were well known to a number of agencies and there were concerns about their health and development, which in the case of Child 1 were long-standing. He had a statement of special educational needs (SEN), a severe communication disability and developmental delay. Child 2 had more recently been diagnosed as having a significant developmental delay. Historically there had been concerns about possible neglect. Mother was convicted of cruelty and received a community sentence. They have remained in the care of the local authority and there is currently no plan to return them to her care. After the children were removed the mother was diagnosed with severe depression.

LEARNING

- *The importance of home visits and not only seeing families in 'settings'*
- *The importance of identifying and naming neglect as a potential concern – to ensure swift action is taken to protect children.*
- *The importance of robust and thorough assessments of potential neglect*
- *The importance of joint working across children's and adult services and 'thinking family'*
- *The need for robust arrangements for safeguarding children in education settings.*
- *The recognition of neglect and children with disabilities – additional vulnerabilities for this cohort.*

SERIOUS CASE REVIEW – CHILD H 2016

Child H was a baby girl who lived with her mother and father at the home of the maternal grandparents. Child H died at the age of six weeks. Medical advice indicated that the death had been caused by inflicted injuries. Child H's parents, Ms M and Mr F, were arrested but subsequently no charges brought. No one has been held to account for Child H's death. The circumstances of the death met the statutory requirement that a SCR be conducted.

LEARNING

- *The importance of distinguishing between parental learning difficulties v disabilities – the thresholds for engagement by other services and the assessment of any needs in the context of parenting capacity.*
- *The importance of thinking family and engaging relevant specialisms (whether adult or children) as part of the assessment process.*
- *The importance of management oversight and supervision of case work to ensure its quality.*
- *Ensuring a clearer understanding of Psychosocial Meetings held at Homerton Hospital.*

JOINT SERIOUS CASE REVIEW / DOMESTIC HOMICIDE REVIEW – CHILD D 2016

Child D and her mother were murdered by mother's ex-partner (father of Child D). There was no significant multi-agency involvement prior to the deaths, although mother reported concerns regarding domestic violence to police and their response has been subject to separate investigation by the Independent Police Complaints Commission (IPCC).

LEARNING

- *Professional curiosity in the context of people experiencing domestic violence and abuse.*
- *Accurate risk assessments of the risk of domestic abuse.*
- *The need for agencies to work together effectively.*
- *The need for robust supervision to ensure high quality work.*
- *The importance of sufficient resources being made available for front-line staff to do their jobs effectively.*

MULTI-AGENCY CASE REVIEW – CHILD L 2016

Child L was a 17 year old male who was fatally stabbed. The assailants (who were found guilty of murder) were of a similar age and were known to Child L. Child L came to the attention of statutory services in the months before he died. On two occasions he was reported missing to the police and had been arrested or had contact with the police on at least seven separate times for drug offences in a number of cities across the UK - including in the period when he had been reported missing.

LEARNING

- *Seeing beyond criminal behaviours to consider if a young person, in particular young men, are potential vulnerable or at risk of harm/exploitation.*
- *Recognition of the increase vulnerability of young people who move across geographical areas as there is greater risk of them falling through statutory service gaps.*

SERIOUS CASE REVIEW – CHILD M 2018

Child M and his sibling were subject to Child Protection Plans following injuries that Child M's sibling sustained whilst in the care of Child M's father. In 2016, Child M was taken to hospital by his mother and on examination was found to have bruising to his face and transverse fractures to both femurs. In criminal proceedings father was found not guilty in relation to the GBH against Child M. Both mother and father were found guilty of child cruelty.

LEARNING

- *The recognition of avoidant behaviour & disguised compliance.*
- *The need for professional curiosity and challenge in the context of ensuring children are safe.*
- *The need to guard against professional optimism.*

MULTI-AGENCY CASE REVIEW – CHADRACK 2018

Chadrack was 5 years old when both he and his mother were found dead at their home in 2016. Chadrack had Special Educational Needs and Disabilities and was non-verbal. From the inquest into their deaths, it was concluded that Chadrack lived alone in the family home for over a fortnight after his mother's death. He was unable to feed himself or seek help. He died of starvation and dehydration.

LEARNING

- *The importance of thinking safeguarding first when dealing with absence, attendance and missing from education.*
- *Ensuring professionals attempt to understanding the context of the child's life and that of the parents / carers.*
- *The practical application of professional curiosity; beyond rhetoric.*
- *The need to rule safeguarding 'in or out' as an issue before anything else.*
- *Keeping children safe in education; proactively asking for information on vulnerabilities which may impact on the child or family network.*

SERIOUS CASE REVIEW - CHILD N & CHILD O 2018

In March 2017, Child N was assaulted by his father and pronounced dead in hospital. His female twin (Child O) sustained serious injuries in the same incident. Father subsequently pleaded not guilty to murder but admitted manslaughter on the grounds of diminished responsibility and in October 2017 was sentenced to indefinite detention.

LEARNING

- *The need to consider identified or unidentified fathers in terms of potential value or risk in the context of parenting capacity.*
- *The need for routine enquiries to be made with respect to the possibility of domestic abuse.*
- *The relevance of cultural / linguistic barriers to understanding and the need to understand the context of the family.*

MULTI-AGENCY CASE REVIEW – RACHEL 2019

Rachel was 16 years and 3 months when she took her own life. Her family, school and local Child and Adolescent Mental Health Services (CAMHS) had been concerned about her well-being for some time, including a risk of self-harm, suicidal ideation and acts. She had also become known to her GP, the local Emergency Department, the London Ambulance Service, the Police and Children's Social Care.

LEARNING

- *The need for professionals to have an holistic family view of support and/ care.*
- *The importance of supporting parents/carers in safety planning and providing opportunities for engagement with professionals.*
- *The need to consider parents' worries and observations in the assessment process.*
- *The impulsivity of young people and the fact sometimes they will tell adults what they think they want to hear.*
- *Professionals needing to remain curious and maintain healthy scepticism in all contexts.*
- *The influence of social media, internet use and media.*
- *The importance of robust safety planning and ensuring all key agencies are alert to potential risks.*

MULTI-AGENCY CASE REVIEW - X 2019

X took his own life in October 2016. He had just had his sixteenth birthday and was in Year 11 at school, preparing for GCSEs. X lived with his mother and father. His older sister had just moved away from home to university, outside London.

LEARNING

- *Drug use and alcohol use amongst young people – particularly the use of Xanax.*
- *The use of the internet and social media in self-harm and suicide.*
- *The need for professionals to support awareness of mental health in young people - Peers as Supporters.*
- *The need to create environments where boys / young men can seek help.*

Auditing

THE CHSCP'S SELF-ASSESSMENT FRAMEWORK

During 2020/21, the CHSCP launched its new Safeguarding Self-Assessment Framework to help organisations make children safer. It replaced the Section 11 audits and Section 157 / 175 audits with the aim of making the process easier to access and update. Whether an organisation is a safeguarding partner, a relevant agency or named within our local arrangements, there is an expectation that the self-assessment is completed. The Self-Assessment programme engaged Social Housing Providers and Out of School Settings (OOSS) for the first time and demonstrated increased engagement by VCS organisations.

EVIDENCE

Evaluation of self-assessment returns from the City of London and Hackney provided reassurance about the sufficiency and focus on safeguarding children. Areas for improvement included increased awareness raising to OOSS on topics such as CHSCP training, policies and guidance. Planned activity going forward will include additional quality assurance of the submitted returns, Peer Review and the introduction of Child Safeguarding Statements in 2022/23.

IMPACT

Launching CHSCP Policy Guidance - Self-Assessment activity by the CHSCP identified that settings were producing increasingly complex and non-user-friendly child protection policies. The CHSCP developed and disseminated Safeguarding & Child Protection Policy Guidance to support organisations in writing their policy and how to structure it for best effect.

ASSURANCE

Child Safeguarding Statements *- The CHSCP is preparing to launch an additional process to help strengthen safeguarding leadership and accountability. This involves the requirement for organisations to complete a Child Safeguarding Statement. Developed from a model in operation in Ireland, Child Safeguarding Statements should be developed once a self-assessment has been completed. To do this, organisations will need to undertake a risk assessment that considers the potential for harm to come to children while they are in the organisation's care. Risk in this respect is the risk of abuse and not general health and safety risk. The risk assessment exercise does not need to follow a prescribed format but should be sufficient to allow organisation to establish whether there are any practices or features of their service that have the potential to put children at risk. It is intended to enhance an organisation's ability to identify potential risks, develop policies and procedures to minimise these risks by responding to them in a timely manner and review whether adequate precautions have been taken to eliminate or reduce these risks.*

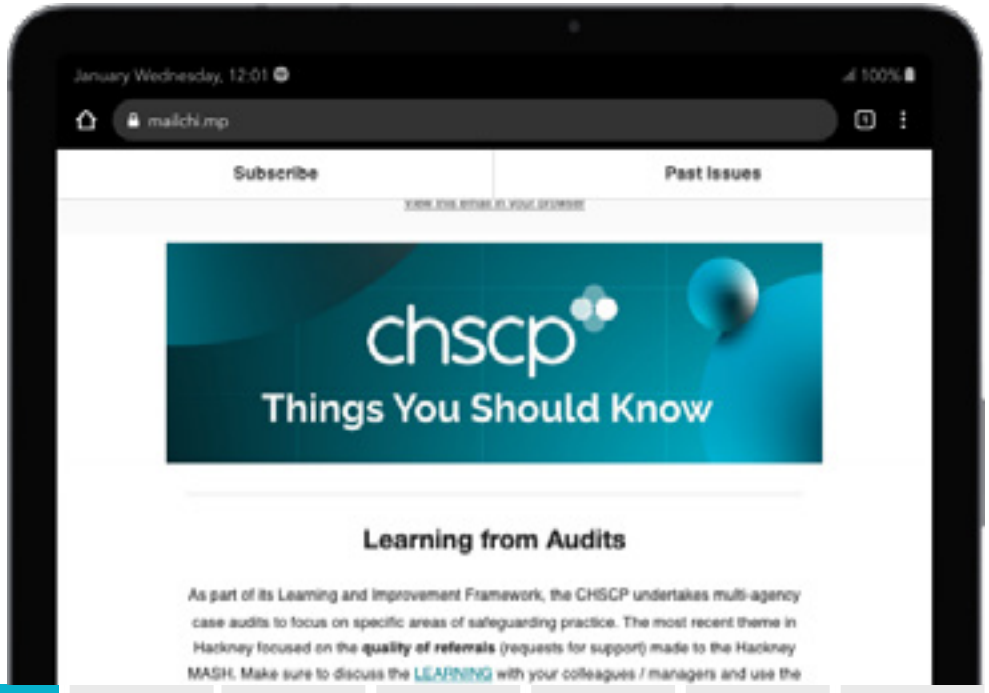
After the risk assessment has been completed, organisations will be required to develop their Child Safeguarding Statement. These are written statements that specify a number of key points:

- ***The nature of the organisation and the services being provided.***
- ***The organisation's commitment to child safeguarding***
- ***An overview of the measures in place to ensure that children are protected from harm. It may also refer to more detailed policies which can be made available on request.***
- ***Any potential risks to a child that have been identified and the actions in place to mitigate these.***

Upon completion, a Child Safeguarding Statements must be signed by the Chief Executive Officer or equivalent. For schools, both the Headteacher and Chair of Governors must sign. For charities, both the CEO and the Chair of Trustees must sign. Child Safeguarding Statements must be shared with all staff members / volunteers. They must be displayed in a prominent place and made available to parents and guardians and members of the public upon request. Child Safeguarding Statements are reviewed within 24 months (or as soon as practicable after there has been a material change in any matter to which the statement refers). Requiring Chief Executives and/or those in senior leadership positions to be directly engaged with and sighted on their individual organisation's strengths and weaknesses, will also help provide clarity on accountability. Being required to publicly display such statements will help with transparency and reinforce messaging about the protection of children and young people.

MULTI-AGENCY CASE AUDITS

The Multi-Agency Case Auditing programme was further developed to focus on specific areas of the safeguarding system. This has allowed multi-agency partners to increase the number of auditing rounds and the breadth of scrutiny whilst adapting rapidly to local or national intelligence. This auditing methodology has received excellent feedback from partners and lessons identified have led to tangible improvements. All audits result in an outcome focussed action plan that the CHSCP uses to track and evidence improvements in front-line practice. Learning is also disseminated to front line staff via the Things You Should Know (TUSK) monthly briefings.



CHILD PROTECTION CONFERENCES AUDITS

LEARNING

- *Tools are already in place to support professionals attending Child Protection Conferences.*
- *There remains work to do in respect of all agencies submitting written reports in a timely manner that have been shared with families in advance.*
- *HCFS systems require review to ensure that professionals are correctly identified and invited to conferences.*
- *Professionals need to submit a written report including information and professional judgements that can support decision making about significant harm for the child.*
- *Professionals should engage families in advance of Child Protection Conferences, including ensuring that their information submitted is relayed. This is easier for professionals when a strengths-based approach is undertaken.*

STRATEGY DISCUSSIONS AUDITS

EVIDENCE

- *There was evidence of **good timeliness** in identifying concerns and convening strategy discussions.*
- *There was also high confidence that the **decisions and actions** made at the strategy discussion **made children safer**.*
- *The significant majority of cases demonstrated the **sharing of sufficient information** to confidently inform decision making and planning.*
- *There was good evidence of **information being provided in a timely manner after the strategy discussion, where this was not immediately available.***
- *The significant majority of cases evidenced **relevant information sharing about significant others** involved with the family.*
- *The significant majority of cases audited were clear on the next steps and timescales for **immediate and short-term protection and support.***
- *Of the cases involving **Serious Youth Violence**, there was evidence that **named professionals** were being identified to support the young person, consistent with the CHSCP's Strategy Discussion guidance.*

LEARNING

- *Prior to participating in a strategy discussion, practitioners should watch the CHSCP video and have to hand the CHSCP Guidance and Agenda template. This will help ensure that all necessary areas are covered, with participants having a clear understanding of the key decisions that strategy discussion should make.*
- *All can be found on the dedicated CHSCP webpage for strategy discussions.*
- *Whilst no professional disagreement was evidenced in the cases audited, it is important that practitioners remain aware of the CHSCP Escalation Policy and are confident in its use.*
- *HCFS should amend its interim case recording template for strategy discussions to match the headings set out in the CHSCP Agenda template.*
- *Improvement is needed in the circulation of formal minutes of strategy discussion minutes to agencies in attendance and other relevant professionals.*
- *Explore options to facilitate opportunities to engage GPs.*
- *Improve the engagement of ELFT at strategy discussions by ensuring ELFT practitioners involved with families (both adults and children) are identified and invited. This improvement to be supported via the introduction of an ELFT role within the new Hackney MASH model.*
- *To ensure that any impact arising as a result of race and ethnicity are consistently considered and evidenced within strategy discussions.*

The Voice of the Child, Family & Community

EVIDENCE

Reviews undertaken during this period have maintained a clear, child centric focus. They have engaged children and their families, with their experiences and views being fully reflected in the findings and recommendations.

EVIDENCE

Homerton University Hospital NHS Foundation Trust uses a range of mechanisms to capture the feedback of service users which includes but not limited to: electronic surveys, the Friends and Family Test and complaints. Information is collected through hand held devices or electronic survey links are sent to the parents. The impact of the pandemic and the reduction in face to face contact with children and families has impacted somewhat on collecting service user feedback. In 2020/21, 100% of the 53 respondents said that Homerton staff made them feel safe.

EVIDENCE

The City of London Corporation commissions Action for Children to complete an annual survey of all the children and young people open to the Children's Social Care Team and Early Help Service. This survey is competed by someone independent from the city, and the information is anonymous, so children and young people can speak freely. This survey constantly highlights the close relationship between the young people and their social worker, whereby they feel able to speak to their social worker if they were worried, especially children who are looked after and care leavers. This survey has also led to changes, when young people raised concerns that they did not have a laptop to use for their college work, this was then picked up and acted on by the Virtual Head. This survey is shared across the organisation, with partner agencies and Members, so that any learning from this survey can be acted on.

EVIDENCE

The Participation service in the City of London engages with children and young people who are looked after and care leavers. Young people have engaged well with the participation service, even though much of the contact has had to be virtual over the past year. More recently face to face activities have been re-established and there has been some joint work with Toynbee Hall to establish young people's views about their experience of being cared for by the City of London. The information obtained from this consultation will support the future development of services in Children's Social Care Services. An area for development within the participation service will be a consistent approach to capturing and reviewing how feedback is obtained. The views and opinions of the young people will be used going forward to help shape services for children and young people. Evidence of the impact on the development of services will hopefully encourage more young people to participate within context of a "you said, we did" approach.

EVIDENCE

The Education and Early Years' Service have been making a film that captures the voice of the children and young people with EHCPs in the City. The final version of this film will be ready by mid-November 2021. This will be launched with partner agencies when completed. The SEND strategy has always placed the voice of the child at the centre of their work, ensuring that parents, carers, children, and young people are consulted on a regular basis through one to one and consultation. They continue to use Inclusive solutions for person centred meetings, and this has proved really good at keeping the focus on the child.

EVIDENCE

ELFT CAMHS has strong People Participation work to capture the voice of young people in our services – they run events with young people, families and carers several times a year to hear directly from young people what they want from their services. In June 2021 the "all about me" event was held, an interactive, reverse conference, where the delegates were the experts. Specifically for Hackney there was recent work with a number of our service users to support recruitment into our services (https://youtu.be/nrrgffzyHck) as some examples. ELFT has NHS mandated surveys, a dedicated people participation lead for East London and as part of our recruitment processes mandate service users on their recruitment panels for staff. The safeguarding children team hold annual service user participation groups in which young people are invited to share their views on a range of safeguarding issues

The importance of capturing the voice of the child is embedded in the safeguarding children policy and safeguarding children supervision policy. Tools are available for practitioners to use to assist in capturing the voice of the child including the "my world triangle" and the assessment framework.

EVIDENCE

Training is continuing and mandatory for front line staff in the City of London Police to raise awareness and gain a different perspective on the impact of police activity on children, to assist embedding the 'Voice of the Child' ethos. This includes development of a 'calling card' around vulnerability /support agencies where police visit an address.

EVIDENCE

Feedback surveys are carried out by Hackney CFS to gather the views of children and young people that we work with, for example the Family Feedback Covid-19 Survey was sent out to children and families between January and March 2021 asking about their experience of support during the pandemic. A children in care and care leavers survey is also undertaken annually. Work is currently taking place to review and redevelop the feedback programme to gather feedback from children, young people and parents/carers that we support across the Children and Families Service and a refreshed programme will be launched in 2022.

EVIDENCE

As a commissioning organisation, the CCG does not provide services directly to children and families. However, engagement and co-production with young people is a CCG Children Young People Maternity and Family (CYPMF) Integrated work stream transformation priority. With this priority in mind, the work stream piloted a Young People's System Influencer programme between November 2020 and February 2021. A group of 10 young people aged 16-25 were recruited from existing engagement groups and employed for 7 weeks to co-produce projects to influence systems.

Each of these young people was assigned two experienced 'System Mentors' who offered support and guidance throughout the delivery of their projects. The young people were also supported to take on their 'System Influencer' roles through another programme role, 'Peer Mentors'. The two Peer Mentors were young people, slightly older than the System Influencers, who acted as a bridge between the influencers and the mentors. The majority of the System Influencers delivered a number of projects touching on issues such as how young people access health and wellbeing support, evaluation of current models of youth engagement by the council and VCS organisations, a project aimed at young black people who are involved in the youth justice system which used art as a tool to explore experiences of trauma, and engagement on the CYP City and Hackney Emotional Health & Wellbeing Strategy.

The programme was extremely positively evaluated with plenty of learning to take forward as part of the delivery of the next phase. There is currently a joint financial proposal in development between Health Watch and LBH/NEL CCG in order to secure funding for two posts to support the delivery of the mainstreamed programme; one of these is a young person's post. Current plans are for the next phase to begin in quarter 3 of 2021/22.

Performance Data

Due to Covid-19, activity in 2020-21 focussed on review of the CHSCP dataset to ensure it remains proportionate and avoids duplication of metrics already captured. The dataset is structured around core indicators with supplementary thematics providing wider context on the data.

EVIDENCE

During the year, the CHSCP was successful in securing DfE funding for a fixed term Strategic Data Analyst post to develop contemporary threat assessments. Data analysis and interpretation will strengthen decision making, improve scrutiny and enhance tactical decision making of safeguarding partners and relevant agencies of the CHSCP. Unfortunately, despite a number of recruitment rounds, the post remains un-filled. Activity is ongoing to appoint.

Front-Line Intelligence

In response to the Pandemic, Contingency Oversight Groups met on a bi-monthly basis during the lockdown. These groups actively considered service impacts, vaccination rates, covid fatigue, workforce pressures, community engagement and the health and wellbeing of staff (staffing levels, protective clothing, access to occupational health, homeworking, and communication channels). In response to feedback, information on bereavement support and services was developed and disseminated to the partnership in May 2020 alongside signposting access to mental health services.

External Learning

The CHSCP is a learning organisation and is constantly looking outwards to identify relevant learning opportunities that may help assist in its role of co-ordinating and ensuring the effectiveness of the safeguarding systems across the City of London and Hackney. Where relevant, national reviews and inspection reports are considered by the CHSCP. Links to NSPCC thematic briefings and wider learning from other local areas continued to be disseminated to front-line staff via CHSCP training and TUSK briefings.

EVIDENCE

Safer Schools Apps were released in the City of London and Hackney in response to Covid-19 and an increase in cyber-enabled offences identified through local and national 'learning' (Pathways to Harm, Internet Matters).

Disseminated Keeping Kids Safe guidance from the Royal Society for the Prevention of Accidents to parents and practitioners, in response to nationwide learning about the impact of Covid-19, Child Death Review intelligence and a local Rapid Review.

Disseminated Safer Sleep guidance to parents and practitioners and developed a dedicated webpage in response to the National Child Safeguarding Practice Review Panel report on Sudden Unexpected Deaths in Infants (SUDI). A multi-agency task group was set up to map current initiatives and identify areas to strengthen the local approach using the 'prevent and protect practice model for reducing the risk of SUDI' framework detailed in the report. Activity is ongoing and will be reported next year.

Disseminated and promoted ICON guidance, an evidence base programme of simple messaging to support parents/carers cope when an infant cries, to professionals and parents following national and local increases in head injuries for children under one during lockdown.

Key Messages for Practice

SAFEGUARDING FIRST

For many organisations, safeguarding is one priority amongst many. Because of this, risk to children and young people can escalate when safeguarding is absent from an organisation's culture and how its professionals and volunteers discharge their duties. It essential that leaders promote such a culture. If anyone has any doubts as to the importance of this message, read The CHSCP's review on **Chadrack Mbala-Mulo**.

To help promote such a philosophy of 'Safeguarding First', always think about safeguarding whatever you are doing, whatever policy you are following and whatever action you might be taking. Professionals should also listen to what children and young people have said they need from those who work with them (Working Together 2018).

CHILDREN HAVE SAID THEY NEED

- **Vigilance:** to have adults notice when things are troubling them
- **Understanding and action:** to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **Stability:** to be able to develop an ongoing stable relationship of trust with those helping them
- **Respect:** to be treated with the expectation that they are competent rather than not
- **Information and engagement:** to be informed about and involved in procedures, decisions, concerns and plans
- **Explanation:** to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- • Support: to be provided with support in their own right as well as a member of their family
- **Advocacy:** to be provided with advocacy to assist them in putting forward their views
- **Protection:** to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee.

Context

Context is key and understanding the context of a child's life is essential for effective safeguarding. In terms of practice, this is about how the partnership works together to better understand the lived experience of children at home, in education and in health, alongside those aspects that are typically outside of the family environment; such as peer groups, places and spaces, and the virtual world that children occupy through their use of technology and social media. Knowing about these contexts will help us determine whether they reflect pathways to harm or pathways to protection. However, it is usual that no one individual has oversight on the detail of everything. In this respect, a first and important step is to make sure that professionals are confident in sharing information and talking with each other. If you are worried about a child or young person, you are allowed to talk with other professionals without fearing you are doing something wrong. You aren't. Talking to each other and sharing information when trying to protect people from actual or likely harm or to prevent a crime is lawful and in the substantial public interest.

Curiosity

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described at the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation to any information they receive and maintaining an open mind. In safeguarding the term 'safe uncertainty' is used to describe an approach which is focused on safety but that takes into account changing information, different perspectives and acknowledges that certainty may not be achievable. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically. Professional curiosity and a real willingness to engage with children, adults and their families or carers are vital to promoting safety and stability for everyone.

Much has been written about the importance of curiosity during home visits and the need for authentic, close relationships of the kind where we see, hear and touch the truth of their experience of 'daily life' and are able to act on it and to achieve similar closeness with parents or carers. Practitioners will often come into contact with a child, young person, adult or their family when they are in crisis or vulnerable to harm. These interactions present crucial opportunities for protection. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm, maintaining an open stance of professional curiosity (or enquiring deeper), and understanding one's own responsibility and knowing how to take action. Children in particular, but also some adults, rarely disclose abuse and neglect directly to practitioners and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across agencies. We know that it is better to help as early as possible, before issues get worse. That means that all agencies and practitioners need to work together – the first step is to be professionally curious.

Curious professionals will spend time engaging with families on visits. They will know that talk, play and touch can all be important to observe and consider. Do not presume you know what is happening in the family home – ask questions and seek clarity if you are not certain. Do not be afraid to ask questions (and difficult questions) of families, and do so in an open way so they know that you are asking to keep the child or young person safe, not to judge or criticise. Be open to the unexpected, and incorporate information that does not support your initial assumptions into your assessment of what life is like for the child or young person in the family.

Challenge

Differences in professional opinion, concerns and issues can arise for practitioners at work and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise, they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner. Differences could arise in a number of areas of multi-agency working as well as within single agency working. Differences are most likely to arise in relation to the criteria for referrals, outcomes of assessments, roles and responsibilities of workers, service provision, timeliness of interventions, information sharing and communication. Safeguarding is everyone's responsibility and front-line staff need confidence in talking with each other about decisions that have been made, discussing any concerns regarding those decisions and where there isn't agreement; escalating those concerns as appropriate. Remember, equally important is the culture of how we work; and it is vital that front-line staff are encouraged to remain professionally curious and to raise issues where they feel that their concerns for children and young people aren't being addressed. To help staff resolve professional differences, the CHSCP has issued a simple Escalation Policy.

Training & Development

Training Summary 2020/21

The training opportunities offered by the CHSCP are designed to meet the diverse needs of staff at different levels within the wide range of organisations that work with children, young people, or adult family members. Sessions range from those that raise awareness about safeguarding and child protection to specialist topics aimed at more experienced staff. The training programme focuses on areas of practice prioritised by the CHSCP, with learning from local and national case reviews integrated into the training material.

As a result of the pandemic, the CHSCP's training programme rapidly pivoted to virtual delivery. The CHSCP team and trainers were swift to adapt and overall, attendance figures increased from 2019/20. Feedback also remained positive with the programme continuing to improve the knowledge and skills of the safeguarding workforce.

EVIDENCE

69 training sessions were held in 2020/21 (70 in 2019/20).

21 safeguarding topics were covered.

Four case review seminars were held involving the Child A and Child C Serious Case Reviews.

17 Reducing Parental Conflict courses funded by the Department for Work & Pensions.

All courses were delivered virtually over an 11-month period (April 2020 training was postponed due to the pandemic).

2853 available training places of which 99% were booked in advance of the course date.

Of the booked places, 685 delegates (24.2%) either cancelled or did not attend the course

66% of attending delegates worked in Hackney, 10% in the City of London, and 24% worked across both Boroughs.

Delegate Numbers

Basic Safeguarding Children Awareness x14	604
BRAVE Webinar x1	28
Child Abuse Linked to Faith & Belief Webinar x1	38
Child A Learning Seminar x2	136
Child C Learning Seminar x2	133
Corrective Rape and Faith Based Abuse & Breast Ironing Webinar x 1	21
Designated Safeguarding Leads Webinars x 5	247
Domestic Abuse and Substance Misuse Webinar x 1	29
DVA Risk Assessment & MARAC Webinar x 1	16
Engaging Perpetrators of DVA Webinars x 2	57
FGM Risk Assessment Tool Webinar x 1	24
So-Called Honour-Based Violence & Forced Marriage Webinar x 1	23
Introduction to Intra Familial CSA Webinar x 2	75
Introduction to Contextual Safeguarding x 1	20
Impact of Neglect & Emotional Abuse x 1	19
MARAC Masterclass Webinar x 2	61
Reducing Parental Conflict Webinars x 17	254
Safe & Together Webinars x 7	117
Safeguarding in a Digital World Webinars x 3	100
Safeguarding Children with Disabilities x 1	61
Small Steps Reducing Extremism x 1	25
VAWG & Harmful Practices Webinar x 1	24
WRAP PREVENT Webinar x 1	24

Agency	2018-19		2019-20		2020-21		Trend
	Number	%	Number	%	Number	%	
CAFCASS	0	0%	1	0.1%	10	0.5%	↗
CCG	10	0.9%	13	1.1%	58	2.7%	↗
City of London - Children's Centres & Nurseries	4	0.4%	8	0.7%	33	1.5%	↗
City of London - Corporation	23	2%	22	1.9%	43	2.0%	↗
City of London - Housing	5	0.4%	6	0.5%	1	0.0%	↘
City of London - Police	15	1.3%	0	0%	27	1.3%	↗
City of London - Schools & Further Education	N/I*	N/I*	N/I*	N/I*	59	2.8%	
City of London - Other	3	0.3%	3	0.3%	8	0.4%	↗
ELFT - Adult Mental Health	55	4.9%	52	4.4%	12	0.6%	↘
ELFT - CAMHS	36	3.2%	32	2.7%	32	1.5%	↔
ELFT - Forensics	3	0.3%	19	1.6%	46	2.2%	↗
Health - Other	5	0.4%	20	1.7%	7	0.3%	↘
Homerton University Hospital	123	10.9%	100	8.5%	165	7.7%	↗
LBH: Children's Centre/Nursery	40	3.6%	70	5.9%	130	6.1%	↗
LBH: Children & Families Service	241	21.4%	320	27.1%	513	24%	↗

* Not included in last year's annual report

Agency	2018-19		2019-20		2020-21		Trend
	Number	%	Number	%	Number	%	
LBH: Hackney Education	32	2.8%	17	1.4%	46	2.2%	↗
LBH: Health & Community Services	21	1.9%	10	0.8%	1	0.0%	↘
LBH: Neighbourhoods & Housing	25	2.2%	14	1.2%	47	2.2%	↗
LBH: Schools & Further Education	74	6.6%	78	6.6%	290	13.6%	↗
LBH: Other	14	1.2%	10	0.8%	21	1.0%	↗
London CRC	0	0%	3	0.3%	1	0.0%	↘
Metropolitan Police	4	0.4%	3	0.3%	4	0.2%	↗
National Probation Service	11	1.0%	34	2.9%	37	1.7%	↗
Public Health	20	1.8%	3	0.3%	8	0.4%	↗
Voluntary & Community Services	125	11.1%	92	7.8%	296	13.9%	↗
Whittington Heath	6	0.5%	8	0.7%	4	0.2%	↘
Other	207	18.4%	201	17%	237	11.1%	↗
Total Places	1124	100%	1182	100%	2136	100%	

Evaluation

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues its practice in monitoring and evaluating the effectiveness of its core training programme. Work undertaken to review the quality of training in 2020/21 has enabled the CHSCP to gain important insight into the difference it is making towards improved outcomes for children and young people.

EVIDENCE

98.4% *of delegates stated that the trainers' facilitation skills, teaching style and knowledge were GOOD (11.4%) VERY GOOD (35%) or EXCELLENT (52%). This is excellent feedback and a testament to the skill and expertise of our internal & commissioned trainers.*

IMPACT

BEFORE *training* ***65%*** *of delegates believed their knowledge was GOOD (40%), VERY GOOD (20%) or EXCELLENT (5%).*

AFTER *training* ***98.2%*** *stated their knowledge was GOOD (18.8%), VERY GOOD (60%) or EXCELLENT (19.4%).*

IMPACT

98% *stated what they had learned would help them safeguard children & young people more effectively.*

95% *of delegates said what they had learnt at the seminars would be useful to them in their work with children and young people.*

97% *of delegates rated the content of the learning seminars on Child C and Child A as GOOD, VERY GOOD or EXCELLENT.*

IMPACT

"The facilitator was excellent, really clear and engaging, approached difficult subject empathically". *(Basic Safeguarding)*

"I have reflected and as a result of the training, I plan to develop training for our staff team on particular aspects to develop confidence and knowledge". *(Designated Safeguarding Leads)*

"What was said that I found key was "It's not about the internet, it's about people and their behaviours." From this, I will challenge young people's behaviour, explain to them how they should behave online and make them aware of the dangers. Also, ways they can make it safer for themselves online". *(Safeguarding in a Digital World).*

"I feel that I am definitely going to use the understanding of the use of denial, minimization and blaming by the perpetrators as well as the techniques to challenge these in my work with them". *(Engaging Perpetrators of DVA).*

"Recommend my colleagues to participate in the training. To support my services users who are victims of domestic abuse. Share information with my colleagues" *(Domestic Abuse and Substance Misuse).*

"I will use the information learned from the training to help parents and myself to notice behaviours and signs that children are at risk - especially signs children are being groomed for gangs". *(Building Resilience Against Violence & Extremism) (BRAVE)*

*"**A very well-run course - reminders were set at reasonable intervals, and the content was exactly as I had hoped for".*** *(MARAC Masterclass)*

"I think the training covered a really broad range in safeguarding children with additional needs and I found it all extremely useful. Also hearing from different people from different fields in the safeguarding team was really helpful". *(Safeguarding Children with Disabilities).*

"I am now more aware of the current issues that children and their families are experiencing This will be demonstrated throughout my daily practice, as I am now better equipped to support families". *(VAWG & Harmful Practices)*

"..... an amazing trainer as she was very informative about the topic and always took the time to listen to other opinions." *(Impact of Neglect and Emotional Abuse on Children and Young People)*

Two Learning Seminars were held on Tashaûn Aird (Child C) a 15-year-old child who was fatally stabbed whilst in the street. The seminar was facilitated by Charlie Spencer, the author of the Serious Case Review (SCR). Tashaun's parents and sister were involved in the seminars and shared their experiences on how they felt Tashaûn's interactions with the various safeguarding agencies had impacted on their lives including Tashaûn's.

IMPACT

"The fact that the parents and sister of the young man who lost his life contributed to the presentation, was both humbling and powerful. I am most grateful to them for sharing their thoughts, feelings and reflections. As professionals we MUST learn from this".

"Understanding the true impact on the family. Having the opportunity to hear first-hand from the parents' perspective. Hearing real, live emotion, distrust, their journey. How things can improve from young people and the necessary steps to prevent this from happening in the future".

"The voice of the parents was crucial to us as professionals remembering we are dealing with people not cases and each child should be seen as an individual not a statistic".

"Engaging parents/ families where they are willing and able has a powerful impact and I'd recommend this approach in future".

"We will be reflecting on this case and others and thinking about how we continue to escalate those cases where children and adolescents are at obvious risk".

Priorities & Pledge

CHSCP Priorities 2021/22

Priority 1: The Health & Stability of the Safeguarding Workforce

Outcome: Safeguarding partners, relevant agencies and named organisations attract, retain, develop, and support their workforce. A healthy and stable workforce contributes to high quality safeguarding practice that improves outcomes for children and young people.

Priority 2: The Voice of Children and Young People

Outcome: Multi-agency safeguarding practice reflects the lived experience of children and young people. The voices of children and young people are central to all aspects of practice across the child's journey in the safeguarding system. These influence action and improve outcomes.

Priority 3: Getting the Basics Right

Outcome: Safeguarding practice in the City of London and Hackney is at least good. Children and young people are effectively protected from harm by early, robust, timely and coordinated multi-agency intervention and support.

Priority 4: The Appetite to Learn

Outcome: Children and young people are effectively safeguarded by professionals being actively engaged with the CHSCP's learning & improvement framework. Leaders encourage independent scrutiny, challenge performance, and embed lessons for practice improvement across their respective organisations.

Priority 5: Making the Invisible Visible

Outcome: The activity of safeguarding partners, relevant agencies and named organisations makes children and young people who live in groups and communities that are less engaged with public services safer. Legislation in respect of Unregistered Educational Settings (UES) is amended by government and the CHSCP obtains reassurance that the safeguarding arrangements of all settings are sufficiently robust.

CHSCP Pledge 2021/22

The Health & Stability of the Safeguarding Workforce - Without a healthy and engaged workforce, no agency can fully participate in and support the work of the partnership. The CHSCP will therefore seek to develop a better understanding of the pressures that staff and volunteers face and the steps that can be taken to mitigate them. This work will be undertaken in the context of what we know about the current conditions – Covid-19, organisational change, and restructure, reduced resourcing levels and increased demand. It will include evaluation of workforce stability, its capacity, and the support available to help deliver high-quality practice.

The Voice of Children and Young People - We will support and enable a culture of working that routinely seeks out and reflects the voices of children and young people. The lived experience of local children and young people and their voices will be evident in the policies we create, the practice we review and the communication channels that our wider partnership creates. Importantly, it will be evident in our casework and our intervention to improve outcomes for children and young people.

Getting the Basics Right - Whilst welcoming innovation, the CHSCP is aware that good practice begins with getting the basics right. We will maintain focus on ensuring these aspects are embedded in our work covering the journey of the child through the safeguarding system. This includes our approach to early help, children in need (including those with SEND), child protection, looked after children and care leavers. We will also concentrate on those areas that require strengthening as identified by our Learning & Improvement Framework, local intelligence and the CHSCP strategic data analyst.

The Appetite to Learn - We are committed to maintaining our improvement journey and to that end, we will actively seek out and embrace opportunities to learn. Our quality assurance activity remains structured on our learning and improvement framework. We will routinely revisit the action plans to ensure that identified improvements are reflected in contemporary practice. Critically, we will respect the independent scrutiny role of the Independent Child Safeguarding Commissioner, the right to 'roam', the right to ask difficult questions and the right to respectfully challenge. Whenever required, safeguarding partners, relevant agencies and named organisations will provide whatever information they can to address a relevant enquiry or concern.

Making the Invisible Visible - The CHSCP will seek to better understand the vulnerabilities that can negatively impact on the outcomes for children and young people, particularly with those for whom oversight, and engagement is limited. We will seek to develop a more complete understanding of existing and emerging harms in the City of London and Hackney and work to mitigate and prevent them. We will map and analyse vulnerability as we know it based on age, location, need and the context of young people's lives, at home, in care and in the public spaces and places (including the internet) they frequent.

What You Need to Know

CHILDREN AND YOUNG PEOPLE

- Nothing is more important than making sure you are safe and well cared for.
- As adults, sometimes we think we always know best... we don't... and that's why your voice is so important.
- This is about you and we want to know more about how you think children and young people can be better protected.
- We want to talk to you more often and we want to know the best way to do this... please help.
- If you are worried about your own safety or that of a friend, speak to a professional you trust or speak to Childline on 0800 1111.

childline

ONLINE, ON THE PHONE, ANYTIME

childline.org.uk | 0800 1111

PARENTS AND CARERS

- Public agencies are there to support you and prevent any problems you are having getting worse...Don't be afraid to ask for help.
- Tell us what works and what doesn't when professionals are trying to help you and your children.
- Make sure you know about the best way to protect your child and take time to understand some of the risks they can face.
- You'll never get ahead of your child when it comes to understanding social media and IT – but make yourself aware of the risks that children and young people can face.

THE COMMUNITY

- You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them.
- We all share responsibility for protecting children. Don't turn a blind eye. If you see something, say something.
- If you live in Hackney, call the Multi-Agency Safeguarding Hub (MASH) on 0208 356 5500.
- If you live in the City, call the Children & Families Team on 0207332 3621.
- You can also call the NSPCC Child Protection helpline on 0808 800 5000.

FRONT-LINE STAFF AND VOLUNTEERS WORKING WITH CHILDREN OR ADULTS

- Make children and young people are seen, heard and helped. **SAFEGUARDING FIRST, CONTEXT, CURIOSITY & CHALLENGE.**
- Your **professional judgement** is what ultimately makes a difference and you must invest in developing the knowledge, skills and experiences needed to effectively safeguard children and young people. Attend all training required for your role.
- Be familiar with, and use, when necessary, the **Hackney Child Wellbeing Framework and/or The City of London Thresholds of Need tool** to ensure an appropriate response to safeguarding children and young people.
- Understand the importance of **talking with colleagues and don't be afraid to share information**. If in doubt, speak to your manager.
- **Escalate your concerns** if you do not believe a child or young person is being safeguarded. This is non- negotiable.
- Use your representative on the CHSCP to make sure that your voice and that of the children and young people you work with are heard.
- If your work is mainly with adults, make sure you consider the needs of any children if those adults are parents.

LOCAL POLITIANS

- You are leaders in your local area. Do not underestimate the importance of your role in advocating for the most vulnerable children and making sure everyone takes their safeguarding responsibilities seriously.
- Councillors Anntoinette Bramble (Hackney) and Randall Anderson (The City of London) are the lead members for Children's Services and have a key role in children's safeguarding – so does every other councillor.
- You can be the eyes and ears of vulnerable children and families... Keep the protection of children at the front of your mind.

CHIEF EXECUTIVES AND DIRECTORS

- You set the tone for the culture of your organisation. When you talk, people listen. Talk about children and young people. Talk about SAFEGUARDING FIRST.
- Your leadership is vital if children and young people are to be safeguarded.
- Understand the capability and capacity of your front-line services to protect children and young people - make sure both are robust.
- Ensure your workforce attend relevant CHSCP training courses and learning events.
- Ensure your agency contributes to the work of CHSCP and give this the highest priority. Be compliant with minimum standards for safeguarding.
- Advise the CHSCP of any organisational restructures and how these might affect your capacity to safeguard children and young people.

THE POLICE

- Robustly pursue offenders and disrupt their attempts to abuse children.
- Ensure officers and police staff have the opportunity to train with their colleagues in partner agencies.
- Ensure that the voices of all child victims are heard, particularly in relation to listening to evidence where children disclose abuse.
- Ensure a strong focus on MAPPA and MARAC arrangements.

HEAD TEACHERS AND GOVERNORS OF SCHOOLS

- Ensure that your school / academy/ educational establishment is compliant with statutory guidance KCSIE.
- You see children more than any other profession and develop some of the most meaningful relationships with them.
- Keep engaged with the safeguarding process and continue to identify children who need early help and protection.

CLINICAL COMMISSIONING GROUPS

- CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations.
- Discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children.

THE LOCAL MEDIA

- Safeguarding children and young people is a tough job.
- Communicating the message that safeguarding is everyone's responsibility is crucial - you can help do this positively.
- Hundreds of children and young people are effectively safeguarded every year across the City and Hackney.
- **This is news.**

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