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Annual Report 2024/2025

Foreword by the Independent Safeguarding Children Commissioner

It has been a year of significant progress and considerable challenge for the City & Hackney Safeguarding Children Partnership (CHSCP) as we have worked to safeguard and promote the welfare of all our children and their families. This Foreword provides a self-assessment and commentary on our key achievements, while also highlighting the areas where we continue to face undeniable difficulties.

In 2024/25, our partnership demonstrated a strong, collective commitment to our core mission. We have seen positive movement in several key areas. Crucially, our multi-agency safeguarding arrangements, including the governance structure and the roles of our lead and delegated safeguarding partners, continue to function effectively. The enduring commitment to independence within our arrangements has been invaluable, providing the 'grit' necessary for the robust scrutiny and constructive challenge that drives our work forward. This is an approach we have chosen to maintain, as it neither weakens nor undermines the ability of our partners to fulfil their statutory functions.

We are proud of the strong performance reflected in recent inspection outcomes. The City of London Corporation received an 'Outstanding' Ofsted rating, with inspectors highlighting the excellent services that are making a significant difference in children's lives. Similarly, Hackney's Children & Families Service was rated 'Good,' a considerable improvement achieved despite a challenging period marked by a cyber-attack and community tensions. Both the Metropolitan Police Service and the City of London Police have also made notable improvements in their handling of child-related cases, with a renewed focus on a 'child first' approach and better investigation processes. These positive inspection results are a clear testament to our focus on maintaining and building upon the foundations of good practice.

Our commitment to learning is another area of progress. We have continued to implement our learning and improvement framework, identifying lessons from multi-agency audits and local case reviews to drive improvements in practice. We published two Local Child Safeguarding Practice Reviews (LCSPRs) this year, for Case A and Child V, and have actively progressed the recommendations from both, as well as from the ongoing Child Q review. This appetite to learn is central to our work, ensuring that we are a reflective and continuously improving partnership. We have once again demonstrated that our partnership will respond to questions concerning the health and wellbeing of our children whenever and wherever they arise, doing so without fear or favour.

Despite these successes, we remain grounded in the reality of the significant challenges we face. The most pressing of these are financial constraints, increased demand, and the rising complexity of cases. We know from our

partners' reports that organisations are grappling with substantial budget deficits. The Metropolitan Police Service faces a $260 million deficit, which will lead to a reduction of approximately 1,700 staff. Hackney Council needs to save $52 million over the next three years. This environment of tightening funds and growing demand is leading to difficult decisions, restructures, and concerns about staff capacity and well-being. Overlaying these circumstances with a significant national reform agenda, whilst creating opportunities, is marked with risk as well. We cannot ignore this reality.

The complexity of cases continues to increase. Agencies like the East London Foundation Trust (ELFT) and Homerton Healthcare NHS Foundation Trust (HHFT) report a sustained rise in emotional distress, self-harm, and complex mental health issues among children and young people. Many of these cases are high-risk but fall below the threshold for statutory social care intervention, creating ethical and clinical dilemmas for our practitioners. We also face ongoing challenges with data accuracy and information-sharing agreements between agencies. These issues can hinder our ability to respond effectively and in a timely manner, an area we are committed to improving.

As we look to the future, our priorities will reflect the need to navigate these challenges. We must continue to focus on the health and stability of our safeguarding workforce, ensuring that staff and volunteers are well-supported amidst ongoing organisational change and increased demand. We must also strengthen our approach to strategic vulnerabilities and pathways to harm, including child sexual abuse, adolescent safeguarding, and the ongoing risks associated with unregistered educational settings.

The CHSCP's commitment is to ensure that every child is seen, heard, and helped. We will proactively tackle racism through our Active Anti-Racist Charter, listen to the voices of children and families to inform our work, and maintain our unwavering focus on the lived experience of children. While the road ahead will be difficult, we are confident that by working together and staying true to our core principles, we can continue to make a real and lasting difference for the children and families in the City of London and Hackney.

Jim Gamble QPM
Independent Child Safeguarding Commissioner
The City & Hackney Safeguarding Children Partnership

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About the Annual Report

The City & Hackney Safeguarding Children Partnership annual report for 2024/25 sets out examples of the learning, challenge, impact, evidence and improvement of the statutory safeguarding arrangements in the City of London and the London Borough of Hackney. It reports on the following activity:

- The governance and accountability arrangements for the CHSCP's safeguarding arrangements alongside a summary of progress against the CHSCP's priorities and pledge.
- The context for safeguarding children in the City of London and the London Borough of Hackney, highlighting key data and the progress made by partners over the reporting period.
- 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.
- The key messages for those involved in the safeguarding of children and young people.

In line with statutory requirements, the CHSCP annual report 2024/25 has been sent to the Child Safeguarding Practice Review Panel and the Multi-Agency Safeguarding Arrangements Unit in the Department for Education.

The CHSCP

Summary

The City 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 2023. The CHSCP's safeguarding arrangements define how safeguarding partners, relevant agencies and other organisations work together to coordinate their safeguarding services. These arrangements include details about how safeguarding partners 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

As set out in WT23, purpose of multi-agency safeguarding arrangements is to ensure that, at a local level, organisations and agencies are clear about how they will work together to safeguard children and promote their welfare. This means:

- There is a clear, shared vision for how to improve outcomes for children locally across all levels of need and all types of harm.
- When a child is identified as suffering or likely to suffer significant harm there is a prompt, appropriate and effective response to ensure the protection and support of the child.
- Organisations and agencies are challenged appropriately, effectively holding one another to account.
- The voice of children and families combined with the knowledge of experienced practitioners and insights from data, provides a greater understanding of the areas of strength and/or improvement within arrangements and practice.
- Information is sought, analysed, shared, and broken down by protected characteristics to facilitate more accurate and timely decision-making for children and families, and to understand outcomes for different communities of children.
- Effective collection, sharing and analysis of data, enables early identification of new safeguarding risks, issues, emerging threats, and joined-up responses across relevant agencies.
- Senior leaders promote and embed a learning culture which supports local services to become more reflective and implement changes to practice.
- Senior leaders have a good knowledge and understanding about the quality of local practice and its impact on 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.

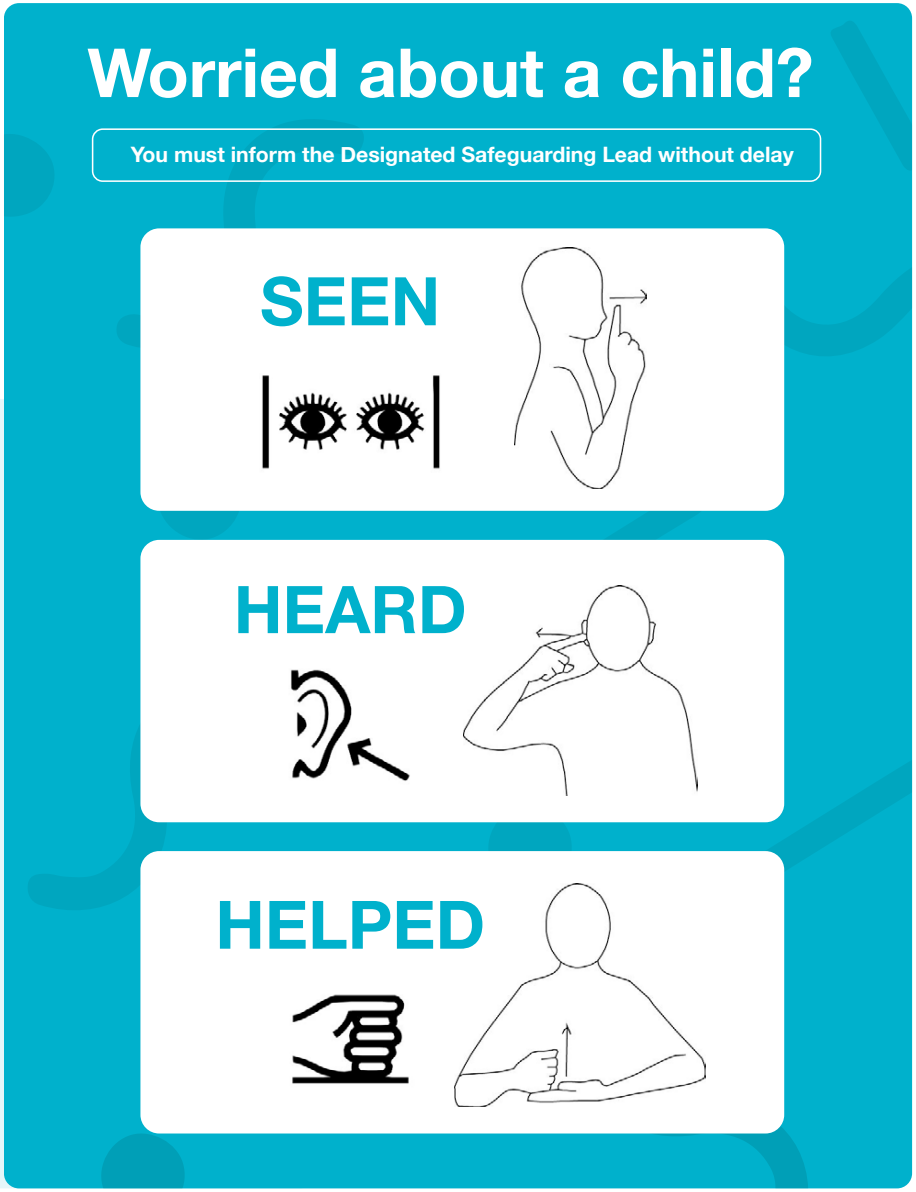
Principles

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 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 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.

The CHSCP's Active Anti-Racist Charter

As a partnership responsible for safeguarding and promoting the welfare of all children, we have zero tolerance for racism, and we are committed to playing our part in eradicating it. The CHSCP's Active Anti-Racism Charter sets out a framework to help us do just that. It describes a range of expectations for how racism can be tackled and how we can help children and their families see, hear and feel the change we seek. It also recognises the demographics of our local workforce and how for many of them, the impact of racism resonates in both their personal and professional lives. Given the range of activity that is ongoing in this space, the Charter does not replace any single-agency initiatives, rather it provides the 'umbrella architecture' against which organisations can test and create their own guidance. All agencies represented on the CHSCP have formally agreed to its contents. The Charter is referenced within our written safeguarding arrangements, and we expect all agencies to adhere to it.

Key Roles & Relationships

STATUTORY SAFEGUARDING PARTNERS

A statutory safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as the local authority, an integrated care board and the chief officer of police. 7.2 These three partners have a joint and equal duty to work together as a team (and with other organisations) to safeguard and promote the welfare of all children. Given the CHSCP covers both the City of London and the London Borough of Hackney, our local safeguarding partners comprise the following:

- **Hackney Council**
- **The City of London Corporation**
- **NHS North East London Integrated Care Board (ICB)**
- **The Metropolitan Police Service (MPS)**
- **The City of London Police**

LEAD SAFEGUARDING PARTNERS

Lead Safeguarding Partners (LSPs) speak with authority for the safeguarding partner they represent, take decisions on behalf of their organisation or agency and commit them on policy, resourcing, and practice matters. They also hold their own organisation or agency to account on how effectively they participate and implement the local arrangements. LSPs are expected to play an active role in the CHSCP's arrangements. This is achieved via leadership within their respective agencies, 1:1s with the Independent Safeguarding Children Commissioner (ISCC) and the LSPs formally meeting as part of a 'Safeguarding Assurance Group'. Safeguarding Assurance Groups include Delegated Safeguarding Partners (see below) and are held separately in the City of London and Hackney. These arrangements help to ensure that LSPs are fulfilling their joint statutory functions. Over 2024/25, the LSPs for the CHSCP were:

- Dawn Carter McDonald, Chief Executive of Hackney Council
- Ian Thomas CBE, The Town Clerk of the City of London Corporation
- Zina Etheridge, CEO Designate of NHS NEL
- Matt Twist, Assistant Commissioner of the MPS
- Pete O'Doherty, Commissioner, City of London Police

CHALLENGE

For the MPS and ICB LSPs, given their spans of control and responsibility for numerous jurisdictions, they are unable to fulfil their functions (in a local context) as defined in WT23. This sets out how LSPs should meet 'sufficiently regularly' with other LSPs, be 'jointly responsible for ensuring the proper involvement of and oversight of all relevant agencies', sign off key partnership documents, set the budget and 'act as a team, as opposed to a voice for their agency alone'. Given these circumstances, the delegation of LSP functions is required. Paragraph 57 of WT23 allows for such delegation via its definition of a Delegated Safeguarding Partner.

DELEGATED SAFEGUARDING PARTNERS

Whilst remaining accountable for any actions or decisions taken on behalf of their agency, LSPs have each nominated a senior officer to deliver the CHSCP's safeguarding arrangements. Known as Delegated Safeguarding Partners (DSPs), this group meets as the CHSCP Executive. They can speak with authority, take decisions on behalf of the LSPs and hold their sectors to account. The joint functions for DSPs are set out on page 29 of WT23. For 2024/25, the statutory DSPs were:

- Judith Finlay, Executive Director of Children's and Community Services (The City of London Corporation)
- Jacquie Burke, Group Director of Children & Education (Hackney Council)
- Diane Jones, Chief Nursing Officer (NHS NEL)
- James Conway, Commander (Central East BCU, MPS)
- Umer Khan, Commander (City of London Police)

Jason Marantz, Hackney's Director of Education and Inclusion and Mark Emmerson, the Chief Executive of the City of London Academies Trust were also standing members of the CHSCP Executive during 2024/25. This arrangement helped to ensure the engagement of education within the CHSCP's safeguarding arrangements.

PARTNERSHIP CHAIR

WT23 sets out that LSPs should appoint a DSP to be the partnership chair, with one of its core functions being to chair all meetings involving DSPs. By introducing the partnership chair, WT23 states that this 'arrangement removes any need for a local area to maintain another chair or independent chair.'

CHALLENGE

Locally, it has been agreed there are exceptional circumstances that justify divergence from WT23. Supported by advice obtained from legal counsel, the CHSCP has decided to maintain its existing system of chairing. Over 2024/25, the Independent Safeguarding Children Commissioner continued to 'facilitate and coordinate' the Executive as part of his existing duties linked to independent leadership and scrutiny. This approach neither weakens nor undermines the ability of DSPs to deliver against their defined functions as set out in WT23. Further detail on the rationale supporting this arrangement has been published on the CHSCP's website HERE.

THE INDEPENDENT SAFEGUARDING CHILDREN COMMISSIONER

The CHSCP's approach to independent scrutiny is built on the fundamental premise that multiagency working neither happens by itself nor via the good will of dedicated staff. Multi-agency work needs to be harnessed and driven and must at its heart be open to independent challenge to do better. It was for these reasons that the role of the Independent Safeguarding Children Commissioner (ISCC) was created in 2019, and whilst its functions incorporate those of an independent scrutineer, they extend beyond this. During 2024/25, Jim Gamble QPM continued as the ISCC. He continued to provide independent leadership, advocacy and scrutiny and supported the CHSCP's unambiguous focus on independence, whilst helping to deliver the necessary 'grit' in our system that drives our multi-agency working. The ISCC's functions include:

- Independently advocates by, for and on behalf of our children and families.
- Provides assurance in judging the effectiveness of services to protect children.
- Provides a rigorous and transparent assessment of the sufficiency of systems and processes that enable partner agencies to fulfil their statutory duties and ensure that children are protected.
- Assists when there is disagreement between the leaders involved in multi-agency arrangements.
- Supports a culture and environment conducive to robust scrutiny and constructive challenge.
- Assesses whether the safeguarding partners are fulfilling their statutory obligations.
- Evaluates arrangements for the operation of the safeguarding partnership, including the purpose and functions of meetings, and recommend appropriate changes.
- Confirms, or not, that effective performance management, audit and quality assurance mechanisms are in place within partner organisations which will support the safeguarding partners to fulfil their statutory obligations, and which will enable the partnership to identify and measure its success and impact.
- Ensures that the safeguarding partners provide independent, robust and effective challenge to each other and to relevant agencies and other organisations.

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 will meet regularly with safeguarding partners through the City of London Safeguarding Children Partnership Board and the Hackney Safeguarding Children Partnership Board. Others are invited when deemed necessary and/or be included in various sub-groups / thematic groups. The relevant agencies to which the CHSCP's safeguarding arrangements apply includes all those agencies defined in part 4 of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018. They include:

- Homerton Healthcare NHS Foundation Trust
- East London NHS Foundation Trust (ELFT)
- All schools (including independent schools, academies, and free schools), colleges and other educational providers.
- The Probation Service (London Division)
- Children and Family Court Advisory and Support Service (CAFCASS)
- Hackney Council for Voluntary Services (HCVS)
- London Ambulance Service (LAS)
- London Fire Brigade (LFB)
- NHS England
- All registered charities within the geographic area of the CHSCP whose staff / volunteers work with or come into contact with children and their families.

SCHOOLS, COLLEGES, EDUCATIONAL AND EARLY YEARS SETTINGS

The CHSCP recognises the vital role of schools (including independent schools, academies, and free schools), colleges, educational establishments and early years settings in safeguarding and promoting the welfare of children and young people. All are designated as relevant agencies within the CHSCP's safeguarding arrangements and have a statutory duty to cooperate with safeguarding partners. Whilst work is ongoing to explore better ways to involve education within our arrangements, the following mechanisms are in place to help achieve this:

- The Director of Hackney Education and Inclusion and a CEO of an Academy Trust being standing members of the CHSCP Executive
- In the City of London, engagement of all schools (and the City of London Corporation's Children's Centre) is secured through its Safeguarding Education Forum.
- In Hackney, schools and Children's Centres continue to be supported via the Designated Safeguarding Leads Forum, Head Teacher briefings and the work of Hackney Education.
- For Private, Voluntary and Independent Early Years settings in both the City of London and Hackney, support and services are available through the work of the Hackney Education and respective forums in both local authority areas.
- Schools, educational establishments and early years settings are also engaged as part of the CHSCP's Learning and Improvement Framework and other activity as required. This may include representation at CHSCP Sub Groups and Thematic Groups.

EVIDENCE AND IMPROVEMENT

Further to the implementation of Working Together to Safeguard Children 2023, and the proposed changes in the Children's Wellbeing and Schools Bill, the CHSCP is seeking to change the way it engages Headteachers within its key governance forums. It was recently agreed that a headteacher representative will be sought for the CHSCP Executive group and expressions of interest have been encouraged from those wanting to join the Hackney Board. Integrating Headteachers more formally into the CHSCP's architecture reinstates a successful arrangement that was in place before 2019. We believe their reintroduction will provide the partnership with crucial expertise, advice, and constructive challenge.

Furthermore, Headteachers will serve as a vital link to the broader education system. Their direct experience of the daily realities faced by children and young people, coupled with their insight into school-based safeguarding practices, will significantly strengthen the CHSCP's strategic oversight and decision-making. This ensures the voice of education is clearly heard and fully integrated into our collective efforts to protect our children.

OTHER 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 to ensure this 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) and Social Housing providers.

DESIGNATED AND NAMED PROFESSIONALS

The Designated and Named Doctors and Nurses for Safeguarding Children take a strategic and professional lead on all aspects of the health service contribution to safeguarding children. Designated and named professionals are a vital source of professional expertise. They have continued to demonstrate their value by offering insight, challenge and support to partners.

THE CHSCP TEAM

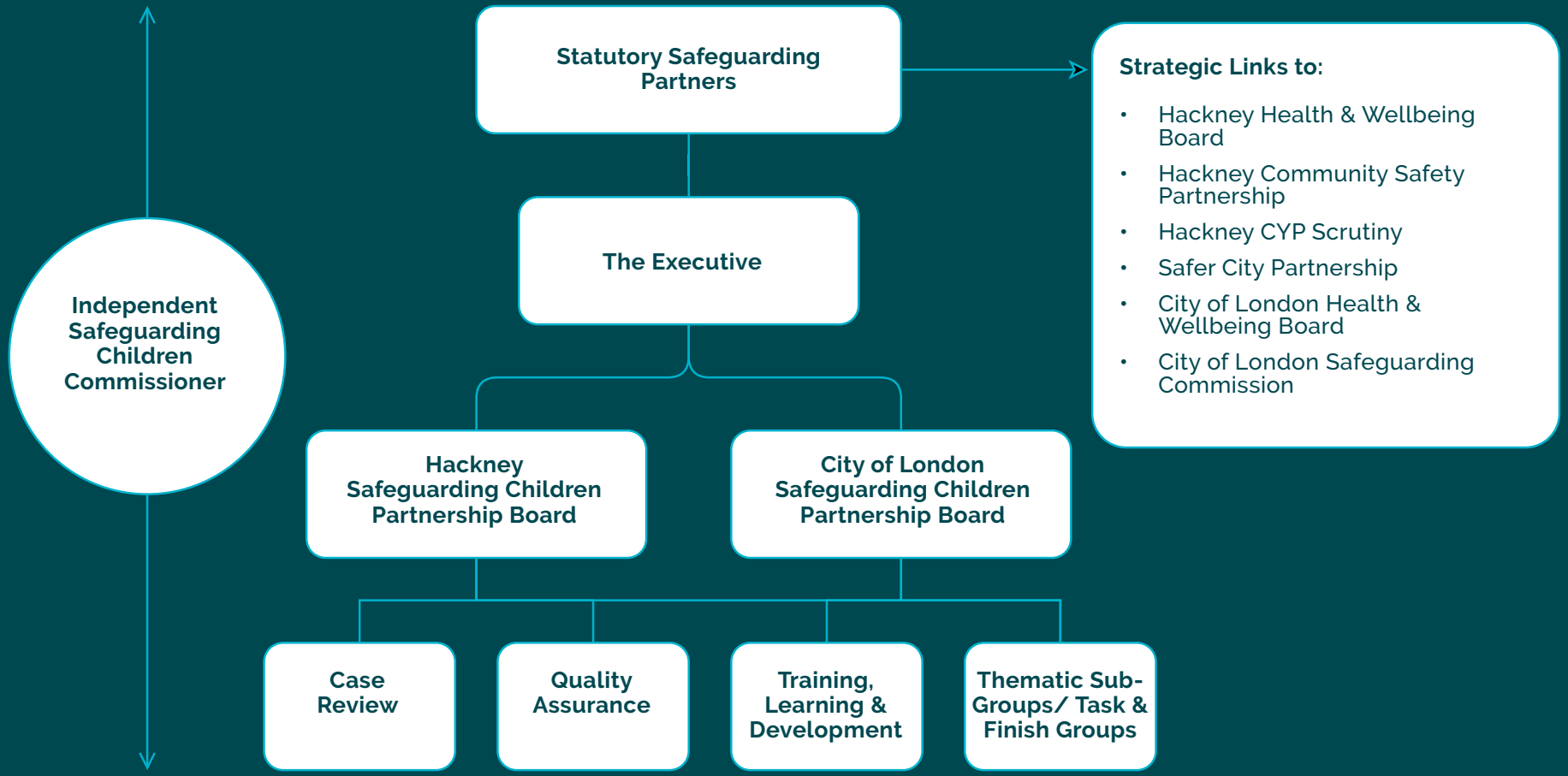
The CHSCP continues to be supported by a dedicated group of staff. The core team includes a Senior Professional Advisor, a Training Coordinator and a Partnership Coordinator.

Independent Scrutiny

In terms of independent scrutiny of the CHSCP's arrangements, activity acts as a constructive critical friend. Such scrutiny is embedded in the culture of how the CHSCP operates and how cross-agency challenge from one agency to another can provide both a level of independence and the support needed for improvement. It is also part of a wider system which includes the independent inspectorates' assessment of safeguarding partners, relevant agencies, and the partnership itself via the Joint Targeted Area Inspection's regime. It similarly features as a fundamental principle of the CHSCP's approach to learning and improvement, reflecting the partnership's commitment to independent challenge and support. It includes:

- Agencies being subject to external inspection and positively responding to any findings and recommendations for practice improvement.
- An ISCC being appointed by LSPs, reporting to them and given the authority to coordinate the independent scrutiny of the local child safeguarding arrangements. This includes the ISCC's 'right to roam' and their ability to access relevant information that tests the sufficiency of the CHSCP's safeguarding arrangements.
- The ISCC being fundamentally independent from local organisations and holding significant experience of operating at a senior level in the strategic coordination of multi-agency safeguarding services. •
- The ISCC providing independent leadership (through engagement, commentary, and lobbying) in respect of local matters relevant to the safeguarding of children and young people.
- The ISCC holding both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. This will ensure ongoing alignment with the existing statutory arrangements for safeguarding adult boards.
- The ISCC engaging with LSPs partners as part of routine 1:1 sessions, and as part of the Safeguarding Assurance Group meetings.
- The ISCC chairing the CHSCP Executive.
- The ISCC chairing the Safeguarding Children Partnership Boards in the City and Hackney.
- The ISCC chairing the Case Review Sub Group to ensure fundamentally independent decision making in respect of the instigating and oversight of reviews.
- A Senior Professional Advisor (SPA) being appointed by safeguarding partners and working on behalf of the ISCC to lead the CHSCP support team.
- The SPA chairing the Quality Assurance Sub Group and being responsible for the delivery of the CHSCP's overall Learning and Improvement Framework.
- The ISCC providing an objective and independent assessment of the effectiveness of the safeguarding arrangements as part of an annual reporting cycle.
- The ISCC being engaged in resolving operational disputes through the CHSCP's dispute resolution protocol.
- Safeguarding partners, relevant agencies and the ISCC actively strengthening networks and building opportunities for local peer review and sector-led support. Where available, this includes independent support as negotiated with safeguarding partners in other local authority areas and/or any such support coordinated via the Local Government Association and the London Safeguarding Children Partnership.
- The CHSCP commissioning external scrutiny as part of its Learning and Improvement Framework to help provide independent reassurance on the quality of practice.

CHSCP Structure 2024-2025



Strategic Links to:

- Hackney Health & Wellbeing Board
- Hackney Community Safety Partnership
- Hackney CYP Scrutiny
- Safer City Partnership
- City of London Health & Wellbeing Board
- City of London Safeguarding Commission

SAFEGUARDING ASSURANCE GROUPS

LSPs in Hackney and the City of London formally meet with the ISCC and DSPs to collectively consider the sufficiency of the local safeguarding arrangements and to fulfil their defined functions as set out on page 27 of Working Together to Safeguard Children 2023. LSPs are jointly responsible for ensuring the proper involvement of and oversight of all relevant agencies, and should act as a team, as opposed to a voice for their agency alone. They

- Set the strategic direction, vision, and culture of the local safeguarding arrangements, including agreeing and reviewing shared priorities and the resource required to deliver services effectively.
- Lead their organisation's individual contribution to the shared priorities, ensuring strong governance, accountability, and reporting mechanisms to hold their delegates to account for the delivery of agency commitments.
- Review and sign off key partnership documents: published multi-agency safeguarding arrangements, including plans for independent scrutiny, shared annual budget, yearly report, and local threshold document.
- Provide shared oversight of learning from independent scrutiny, serious incidents, local child safeguarding practice reviews, and national reviews, ensuring recommendations are implemented and have a demonstrable impact on practice (as set out in the yearly report).
- Ensure multi-agency arrangements have the necessary level of business support, including intelligence and analytical functions, such as an agreed data set providing oversight and a robust understanding of practice.
- Ensure all relevant agencies, including education settings, are clear on their role and contribution to multi-agency safeguarding arrangements.
- Ensure how the experiences of children and families shape the delivery of local arrangements, in particular how those with protected characteristics engage in service design.
- LSPs will also maintain oversight of the key risks within the local safeguarding arrangements and the effectiveness of the partnership in mitigating these.

THE CHSCP EXECUTIVE

The CHSCP Executive comprises the DSPs from both the City of London and Hackney and includes representation from the education sector. It is established for the purposes of DSPs discharging their functions as set out on page 29 of Working Together to Safeguard Children 2023. DSPs are sufficiently senior to be able to speak with authority, take decisions on behalf of the LSP and hold their sectors to account. The DSPs should have the authority to carry out these functions, while ultimate accountability remains with the LSP as the individual responsible for the delivery of the statutory duties of the safeguarding partners. Through the CHSCP Executive, DSPs maintain oversight of the quality and compliance of the delivery of agreed shared priorities. Processes are in place to provide assurance that multiagency practice is reviewed and operating well. Where this is not evident, DSPs should have the capacity and resource from their own agencies to engage, respond and improve operational systems and practice. The Terms of Reference for the CHSCP Executive can be read HERE.

As part of its continued commitment towards transparency, the CHSCP Executive publishes summaries of its meetings. These can be found HERE.

SAFEGUARDING CHILDREN PARTNERSHIP BOARDS

The Safeguarding Children Partnership Boards in Hackney and the City of London are established by safeguarding partners to drive the work of the CHSCP. They are tasked with ensuring ongoing collaboration of safeguarding partners and relevant agencies in their work to safeguard and promote the welfare of children and young people. These groups comprise representatives from safeguarding partners and several relevant agencies. They include named and designated professionals. Both are independently chaired by the ISCC and are responsible for delivering the CHSCP business plan. The Terms of Reference for both Boards can be found HERE, with the core membership of each being available HERE.

EVIDENCE

The Boards in the City of London and Hackney met quarterly during 2024/25. For each meeting, Board members are expected to submit partner agency updates that focus on key issues within their respective agencies alongside a specific theme identified for deeper scrutiny. Over the reporting period, these themes included a focus on how agencies were communicating and responding to the lessons identified by the CHSCP's learning and improvement framework, the support and services provided between 3pm and 7pm (where the risk of youth violence, exploitation and extra-familial harm can increase), how agencies are engaged in the Prevent agenda and a general update on progress.

EVIDENCE

The **Hackney Safeguarding Children Partnership Board** and the **City of London Safeguarding Children Partnership Board** repeatedly discussed the impact of the new national guidance, Working Together to Safeguard Children 2023, particularly the proposal for a partnership chair. This raised concerns about decision-making authority. The unique dual-borough partnership between Hackney and the City of London was a key consideration in these discussions. By March 2025, new arrangements were approved, and the risk of the CHSCP being uninfluential as a strategic body was lowered from red to amber.

The CHSCP's **Risk Register and Operational Risk Register** were standing items, with some concerns focusing on data. A new risk was added for the Met Police's Connect system due to challenges with data accuracy and delays in reporting. Disagreements over the risk rating of birth data also highlighted persistent issues with data-sharing agreements between agencies.

Updates on **case reviews** were also a consistent agenda item. The boards considered Rapid Reviews and Local Child Safeguarding Practice reviews. A significant concern discussed at both boards was the potential for an Information Sharing Protocol (drafted in response to the Child Q review) to undermine the independence of learning reviews. This was resolved through engagement with the Child Safeguarding Practice Review Panel, who agreed to remove the primary issues of concern raised by the CHSCP (that sharing of interview records and other material between learning and conduct processes would be automatic). An 'advisory framework' responding to this issue was subsequently issued by the Panel and IOPC.

The funding for the **IRIS domestic violence service** was a major point of discussion. In 2024, the boards were briefed that Public Health intended to withdraw funding, as they felt it was not an appropriate use of their budget. The potential loss was seen as a significant risk. By March 2025, the risk was mitigated for the short term, as the NHS North East London ICB agreed to take on the full cost for the 2025/26 financial year while a long-term business case was being developed.

GP Patient Access System: A presentation in June 2024 highlighted the new system that gives patients online access to their medical records, including correspondence from children's social care. It was recommended that professionals are reminded of the requirement to redact sensitive data.

Continued overleaf.

EVIDENCE CONTINUED

The City of London pilot of the GCP2 toolkit for identifying neglect was discussed. The tool was found to have a small but positive impact, helping practitioners distinguish low-level neglect. The board decided to continue its use and closed the related action.

The Prevent team in the City of London gave a detailed presentation on their program in March 2025, in light of a national incident. The City board requested a piece of work, through audit or a themed approach, around the increased vulnerability of neurodivergent children to pathways of radicalisation.

The boards regularly received updates on inspection outcomes and was also updated on several new and ongoing projects. Some examples include:

- **New Children's Homes:** An initiative to open two new children's homes in Hackney was presented. These homes are intended to keep children with complex needs in the borough, providing a stable environment and improving care quality while also reducing costs.
- **School-Based Health Services:** A new service was presented, designed to provide flexible, targeted healthcare for schools using a neighbourhood model and digital tools.
- **Immunisation Strategy:** A new strategy was presented to improve vaccination coverage and address inequalities. A key concern was the ad-hoc nature of government funding and the upcoming end of MMR catch-up funding.
- **Trauma-Informed Guidance:** New guidance for child victims of domestic abuse was developed and shared to promote a system-wide trauma-informed response.

Attendance

CHSCP EXECUTIVE

Organisation	Jun 24	Aug 24	Oct 24	Dec 24	Dec 24 (Hackney DSPs)	Jan 2024	Attendance
City of London Corporation	✓	✓	✓	✓	—	✓	100%
Hackney Council	✓	✓	✓	✓	✓	✓	100%
NHS NEL	✗	✓	✓	✓	✓	✗	66.6%
MPS	✗	✓	✗	✓	✗	✓	50%
COL Police	✓	✓	✗	✓	—	✓	80%

HACKNEY SAFEGUARDING CHILDREN PARTNERSHIP BOARD

Organisation	Jun 24	Sep 24	Nov 24	Mar 25	Attendance
CAFCASS	✓	✓	✓	✓	100%
Hackney Education	✗	✓	✓	✓	75%
London Fire Brigade	✗	✓	✗	✗	25%
Hackney Children & Families Service	✓	✓	✓	✓	100%
Hackney Community & Voluntary Service	✗	✗	✗	✗	0%
Homerton Healthcare NHS Foundation Trust	✓	✓	✓	✓	100%
NHS North East London (City & Hackney)	✓	✓	✓	✓	100%
East London NHS Foundation Trust	✓	✓	✓	✓	100%
Hackney Housing Services	✓	✗	✓	✗	50%
Metropolitan Police Service	✓	✓	✓	✓	100%
Probation Service	✗	✓	✓	✗	50%
Public Health	✓	✓	✓	✓	100%

CITY OF LONDON SAFEGUARDING CHILDREN PARTNERSHIP BOARD

Organisation	Jun 24	Sep 24 Ofsted	Nov 24	Mar 25	Attendance
CAFCASS	✗	—	✓	✓	66.6%
City of London Children's Services	✓	—	✓	✓	100%
East London NHS Foundation Trust	✓	—	✓	✓	100%
London Fire Brigade	✓	—	✗	✗	33.3%
Homerton Healthcare NHS Foundation Trust	✓	—	✓	✓	100%
NHS NEL	✓	—	✓	✗	66.6%
City of London Police	✓	—	✓	✓	100%
Probation Service	✓	—	✓	✗	66.6%
Public Health	✗	—	✓	✗	33.3%

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.

Expenditure

Reviews	£32,650
Staffing and Travel	£326,282
Training, Learning & Development	£17,322
Printing, Supplies and Equipment	£4,320
Venues & Miscellaneous	£6,874
Total Expenditure	**£387,448**

Income

Hackney Council	£227,317
City of London Corporation (incl. CoL Police)	£29,480
Hackney Education	£24,480
East London NHS Foundation Trust	£24,480
North East London ICB	£12,000
Homerton Healthcare NHS Foundation Trust	£12,000
Metropolitan Police Service	£5,000
Probation Service (London Division)	£3,051
Use of Reserves	£31,517
Total Income	**£419,325**

Communication

CHSCP WEBSITE

Number of unique visitors to the site:
17,720
Increase of 1,553

Monthly average of visitors:
1,477

Visitors from the UK
11,553 (66%)

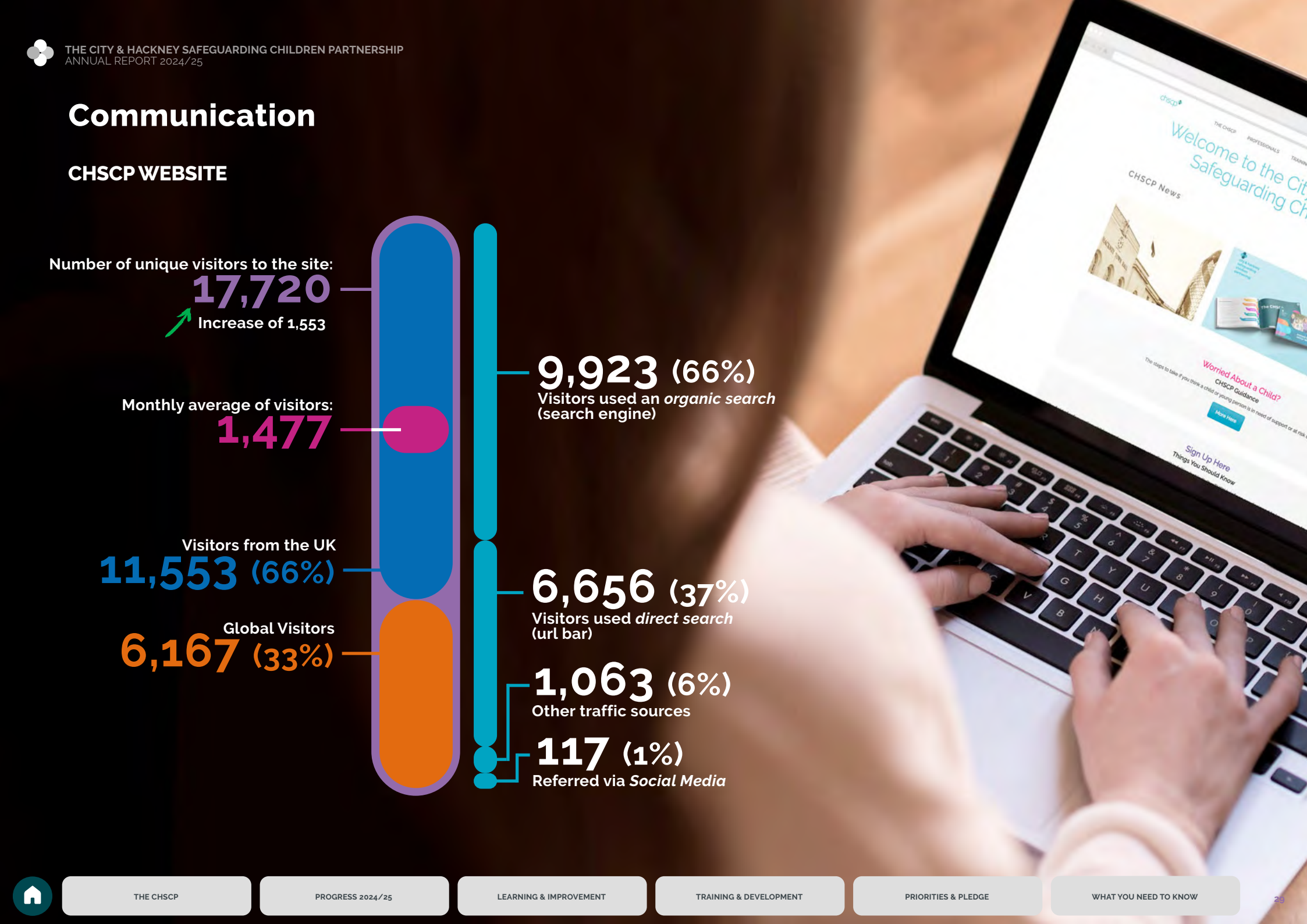
Global Visitors
6,167 (33%)

9,923 (66%)
Visitors used an *organic search* (search engine)

6,656 (37%)
Visitors used *direct search* (url bar)

1,063 (6%)
Other traffic sources

117 (1%)
Referred via *Social Media*



PAGE INTERACTION

10 most popular web pages

www.chscp.org.uk

Homepage
7,754 views

Case Reviews
2,853 views

Key People
1,935 views

Learning & Improvement
1,851 views

Early Help in Hackney
1,507 views

Child Safeguarding Practice Review – Child Q 1,290 views

Our Arrangements
1118 views

E-Learning
809 views

Allegations Against Professionals
762 views

Child Safeguarding Statements
713 views

PRIVATE FOSTERING APP

The CHSCP continues to promote its Private Fostering App. 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 'TUSK' briefings (Things You Should Know). These are circulated to subscribers and cascaded by safeguarding partners, relevant agencies and named organisations. The number of subscribers to the TUSK fluctuated between 1,416-1,476 subscribers during 2024-2025, with an average of 1,446 each month. This is a drop from the maximum of 1,680 subscribers noted the previous year.

Published TUSK briefings can be found HERE.

YouTube

YOUTUBE

The CHSCP has produced several video guides covering a range of safeguarding topics. These can be viewed HERE.

These have attracted 9,987 views to date, an increase of 4,546 views in comparison to the previous reporting period.

Progress 2024/25

The CHSCP's Priorities

PRIORITY 1

THE HEALTH & STABILITY OF THE SAFEGUARDING WORKFORCE

The CHSCP Executive and both Boards consistently monitors this priority through the CHSCP's risk register, where workforce health and stability remain as a standing risk. Meetings regularly address issues related to workforce stability, capacity, and well-being, particularly in the context of financial pressures and new legislation.

A key concern over 2024/25 was the significant organisational change and restructuring taking place across many organisations. For instance, throughout the reporting period, Hackney Children and Families Service (HCFS) began to implement a flatter management structure aimed at increasing the number of permanent staff and improving stability. This included a restructure of the MASH to reduce social work roles while strengthening early help positions. These financial and structural changes are a direct response to budget constraints. Additionally, the new Families First Partnership Programme, a major government reform, is seen as a potential "seismic shift" for the partnership that will require considerable focus, resources, and effort. Underpinned by changes to statutory guidance and proposals in the Children's Wellbeing and Schools Bill, these reforms—along with new duties, such as those related to children educated at home—introduce a risk of 'organisational churn' and workforce stability concerns.

Financial pressures are indeed prompting many organisations to implement significant cost-saving measures. In relation to the Families First reforms, concerns have been raised that agencies will be competing for a limited pool of qualified professionals. Meetings also highlighted the difficulty in recruiting for roles such as designated nurses for looked after children. The need for updated training and professional development remains crucial in the context of these legislative and policy changes. The new reforms will introduce "differently qualified staff," but clear guidance on their training requirements is not yet available from the Department for Education (DfE). This creates a need for cohesive, joined-up training across all agencies. Inter-agency collaboration and communication remain central to managing these workforce challenges.

PRIORITY 2

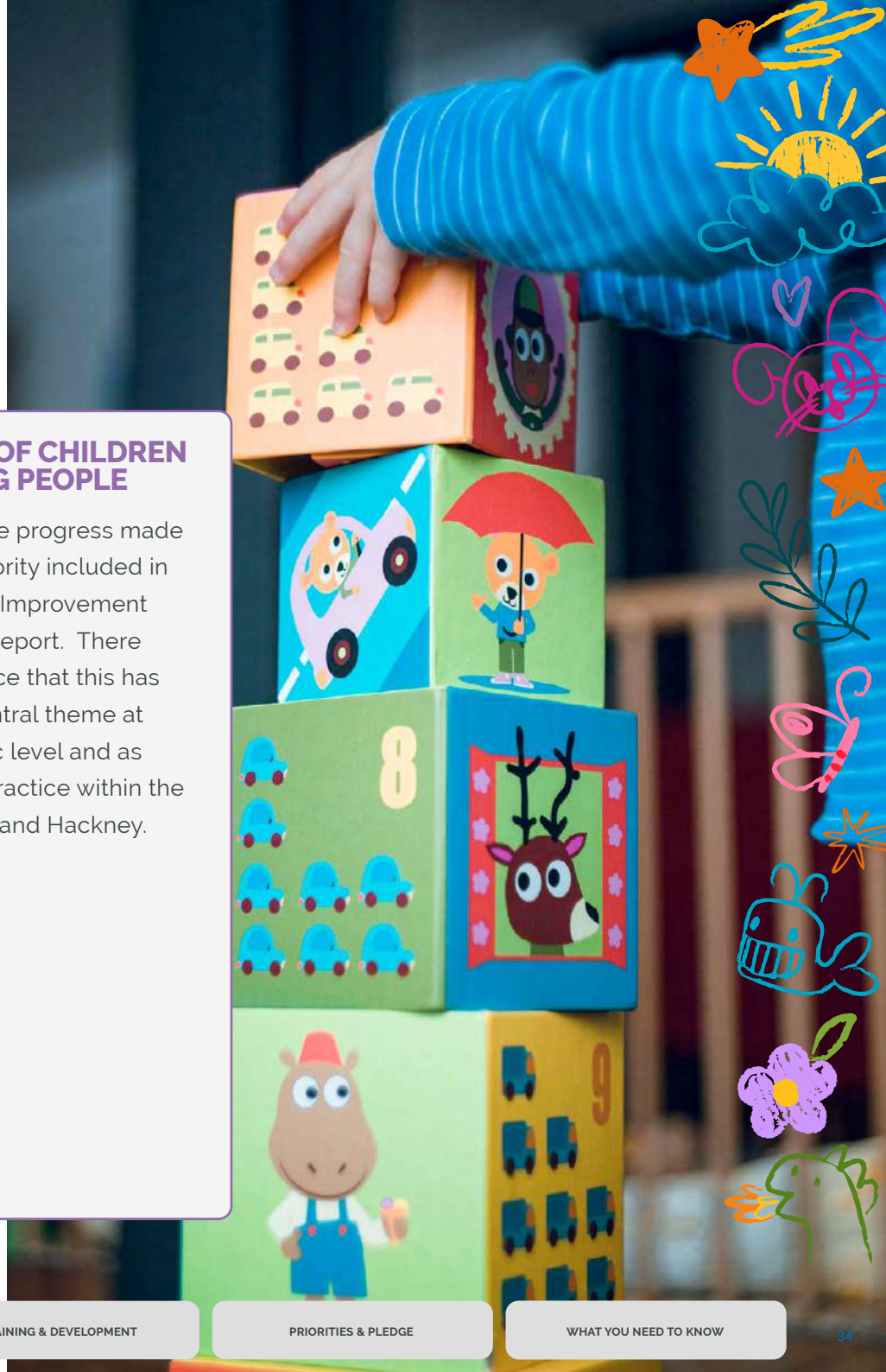
ACTIVE ANTI-RACIST PRACTICE

Partners are continuing to consider and advance their focus on anti-racist practice, with the Executive launching the CHSCP's Active Anti-Racist Charter during 2024/25. The charter is designed as an umbrella document to be used alongside existing organisational policies, guiding the partnership's efforts. The Executive Group decided that the charter's impact would be measured at Board level through partner updates in 2025/26 and via existing scrutiny processes like audits and reviews.

PRIORITY 3

THE VOICE OF CHILDREN AND YOUNG PEOPLE

Examples of the progress made against this priority included in the Learning & Improvement section of this report. There is good evidence that this has remained a central theme at both a strategic level and as part of direct practice within the City of London and Hackney.



PRIORITY 4

GETTING THE BASICS RIGHT

The CHSCP maintained its priority on keeping its local policies and guidance up to date and routinely promoting these via its TUSK briefings. Practice in many areas of safeguarding children is good as reflected in the outcomes of inspection activity.

The City of London Corporation was rated as Outstanding in its 2024 inspection. This highlighted, *'Children living or arriving in the City of London receive excellent services that are making a significant difference to their lives. Starting from the very strong service seen at the last inspection, a highly effective senior leadership team has developed services further and continued to make improvements'*,

In Hackney, its Ofsted inspection undertaken in 2024 identified, *'MASH social workers recognise and understand risk to children living in homes where there is domestic abuse and conflict, substance misuse and alcohol misuse. Workers respond quickly to immediate risks. They exercise professional curiosity and consider the family's history and past incidents in context, involving the multi-agency network when required. Children and their families are quickly directed to the most suitable agency to intervene and support them'.*

In January 2025, the Met Police was assessed as having made improvements and was removed from an enhanced level of monitoring by the police inspectorate. His Majesty's Inspector of Constabulary Lee Freeman said: *"I am pleased with the good progress that the Metropolitan Police Service has made so far. Whilst there is still a significant amount of work to do, I have recommended removing the service from our enhanced level of monitoring, known as Engage, and return it to routine monitoring. I am reassured by the plans that the commissioner has put in place to continue making sustainable improvements. We will continue to monitor the progress of the Metropolitan Police Service to make sure those living and working in the capital are getting the service they deserve from their force."*

In July 2025, the Police Efficiency, Effectiveness and Legitimacy assessment of the City of London Police was published by HMICFRS. This identified: *"The City of London Police is outstanding in how and when it records crime. This improvement is testament to the force's investment of time, effort and resources in crime recording. The force has also significantly improved the timeliness with which it records crime. This means investigations and support for victims begins sooner. I was pleased to find improvements in the management and scrutiny of criminal investigations. The force has invested in governance and performance processes to improve and maintain its investigative standards. This has led to continued performance improvements. Overall, we found that investigations were thorough and well supervised. Investigators look for opportunities to bring offenders to justice, even when victims are unwilling or unable to proceed."*

PRIORITY 5

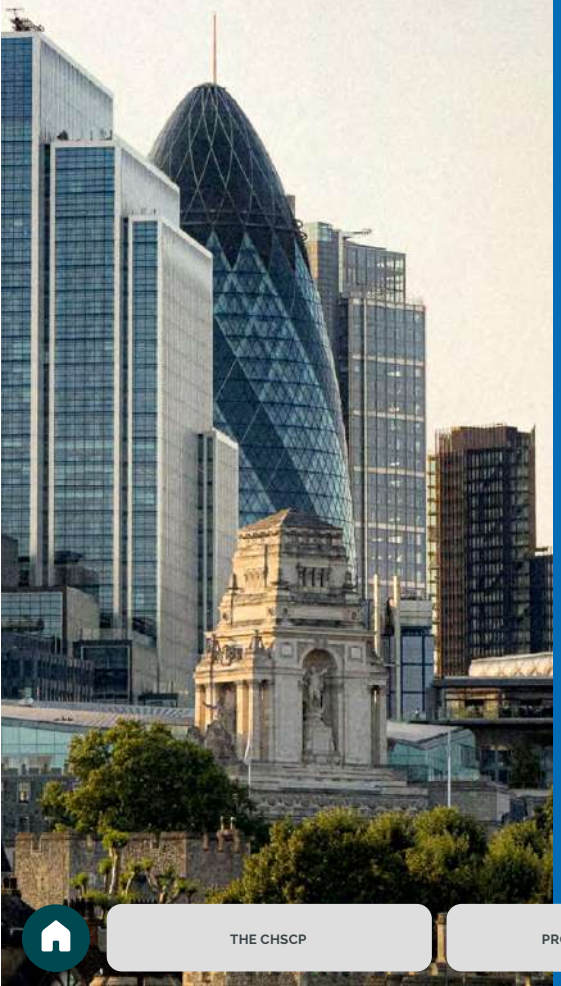
THE APPETITE TO LEARN

Progress against this priority remains strong. Whether through reviews, auditing or other activity, the CHSCP's Learning & Improvement framework continues to identify lessons and drive practice improvement. Our local focus on independent leadership and scrutiny via the ISCC remains a key component in this context. During 2024/25, the Boards tested the effectiveness of how learning was being cascaded to front-line practitioners.

PRIORITY 6

MAKING THE INVISIBLE VISIBLE

During 2024/25, progress in respect of the UES agenda remained slow on a practical level. Changes are awaited from the Children's Wellbeing and Schools Bill. If passed into legislation, there is likely to be a degree of regulatory shape introduced. Whilst welcome, there remain concerns about the impact of the enhanced monitoring regime for children who are electively home educated. There are also concerns about the potential loopholes that could exist by way of UES still being able to operate broadly as they are (with reduced hours) – hence avoiding registration and regulation. In April 2025, the CHSCP's ISCC issued a public statement on this matter. This can be read HERE.



City of London Safeguarding Snapshot 2024/25

The City of London, often referred to as the "Square Mile," is characterized by its small residential population and a significant working population. According to the 2021 Census, the residential population is 8,579, while the daily workforce is almost 615,000 (Office for National Statistics 2022). The residential demographic is notably young, with a large proportion of working-age residents. Only 14% of the population are aged 65 or over, and around 8% are under 18. This youthful trend is complemented by high life expectancy rates; between 2013 and 2017, life expectancy at birth was 88.8 years for males and 90.7 years for females, which is higher than the national average.

The City's demographic composition also reveals interesting patterns in family life, housing, and diversity. There are approximately 430 families with 713 children under 18, residing in 4,900 households, with an average size of 1.7 people. The area is ethnically diverse, with 42% of residents identifying as being from a Black and Global Majority background. There is a large Asian population (16.8% of the population), many of whom live on the east side of the City of London. While a place of great affluence, the Square Mile also has pockets of deprivation, with the Portsoken ward being among the top 20% most deprived areas in the country. To address housing needs, the City Corporation owns 1,923 social rented homes across 12 estates, with two located within the Square Mile and the rest spread across six London boroughs.

Within the City, there is one maintained primary school, four independent schools and several higher educational establishments. It has no maintained secondary schools. Most 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.

Healthcare provision in the City of London is unique due to its dense workforce and small residential base. The Neaman Practice is the only NHS GP practice within the City's boundaries, primarily serving residents in the northwest. Due to proximity and accessibility, approximately 20% of residents, particularly those in the eastern wards like Portsoken, are registered with GP practices in the neighbouring borough of Tower Hamlets.

713
children under 18 (Census 2021)

8.3% of total population (Census 2021)

23.2%
of children in primary schools in receipt of free school meals

24
cases referred / stepped down to the City's Early Help Team

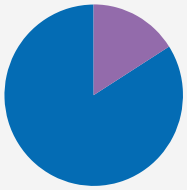
26
Team around the Family (TAF) meetings held

6
children going missing from care during 2024/25

3
children going missing from home during 2024/25

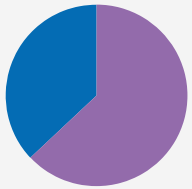
709
contacts to the City Children & Families Team Hub

58
Referrals



16%
re-referrals

8
statutory social work assessments completed by The City Children & Families Team



63%
of assessments completed within 45 days

6
child protection investigations

2
children on a Child Protection Plan as of March 2025

11
Children in Need as of March 2025

5
children looked after as of March 2025

3
MARAC meeting cases involved children

122
contacts to the LADO

0
Private Fostering arrangements as of March 2025

Hackney Safeguarding Snapshot 2023/24

According to the 2021 Census, Hackney's population stood at 259,200, Hackney ranked 68th for total population out of 309 local authority areas in England, which is a fall of two places in a decade. Hackney remains a relatively young borough with almost half of its population between 22-45 years old. That said, overall population sizes for under 19 and under 24 years old have declined slightly from 25.1% and 33.9% respectively since 2011.

Hackney is defined as a super-diverse borough. Almost 40% of the population was born outside of the UK. There is a significant 'Other White', Black and Turkish/Kurdish communities. A large Charedi Jewish community is concentrated in the North East of the borough. 89 different main languages are spoken in Hackney, out of a total across England of 96 main languages. Just over a third of Hackney's residents have stated on the Census they had 'no religion'; followed by the second largest group who are Christian. Hackney has significantly more people of the Jewish and Muslim faiths than England.

Hackney continues to face significant economic and social challenges despite being a hub for creative and tech industries. It has the third highest rate of income deprivation in London. Over 1 in 100 residents were destitute in 2022, equating to almost 1,600 households. Hackney has the 7th highest number of children living in low-income families of any borough in London, with the highest concentration in the North of the borough. With regards to child poverty, this is 25% for children living in income deprived households or 43% when defined as 'children not having enough resources to meet minimum needs, including taking part in society'. This places Hackney as the third highest rate of child poverty in London. There are over 8,500 households on Hackney's housing waiting list, many of whom are living in overcrowded conditions.

Crime levels have fallen between 2019/20 and 2022/23 in Hackney with 1,913 fewer victims. Hackney has recently seen reductions in serious youth violence, gun crime, knife injuries (under 24 years), knife possession, and lethal barrelled discharges. Referrals to the Domestic Violence Intervention Service have reverted to pre-pandemic levels of around 25 referrals a week.

The education system in Hackney is characterized by a mix of primary and secondary schools. The borough has a notable number of "Outstanding" schools rated by Ofsted. In 2024, Hackney ranked 35th of all local authorities on the percentage of pupils achieving a Good Level of Development. Historic attainment gaps persist in 2023. For Key Stage 2 pupils (age 11), Hackney is ranked 6th of all local authorities nationally on the percentage of pupils achieving the expected standard in reading, writing and maths. At KS4 (end of Year 11), Hackney is in the top twenty local authorities nationally. Performance of economically disadvantaged and Special Educational Needs and Disabilities pupils are consistently strong.

Approximately
57,291
children and young people under 18

21% of total population

22.1%
of under 16s live in a low-income family

41.1%
of primary pupils eligible for free school meals

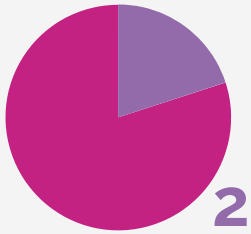
48.9%
of secondary pupils eligible for free school meals

609
families with children under 5 received Early Help MAT intervention

407
new early help cases (families) identified and supported through the MAT process

14,649
contacts to Hackney CFS

3,653
referrals



20%
re-referrals

3,439
assessments completed by Hackney CFS

91%
of assessments were completed within 45 days

1,352
child protection investigations

215
Children on a Child Protection Plan as of March 2024

382
children & young people looked after as of March 2024

296
MARAC meetings involving children and young people living in families with domestic violence

463
contacts to the LADO

15
Private Fostering arrangements as of March 2024

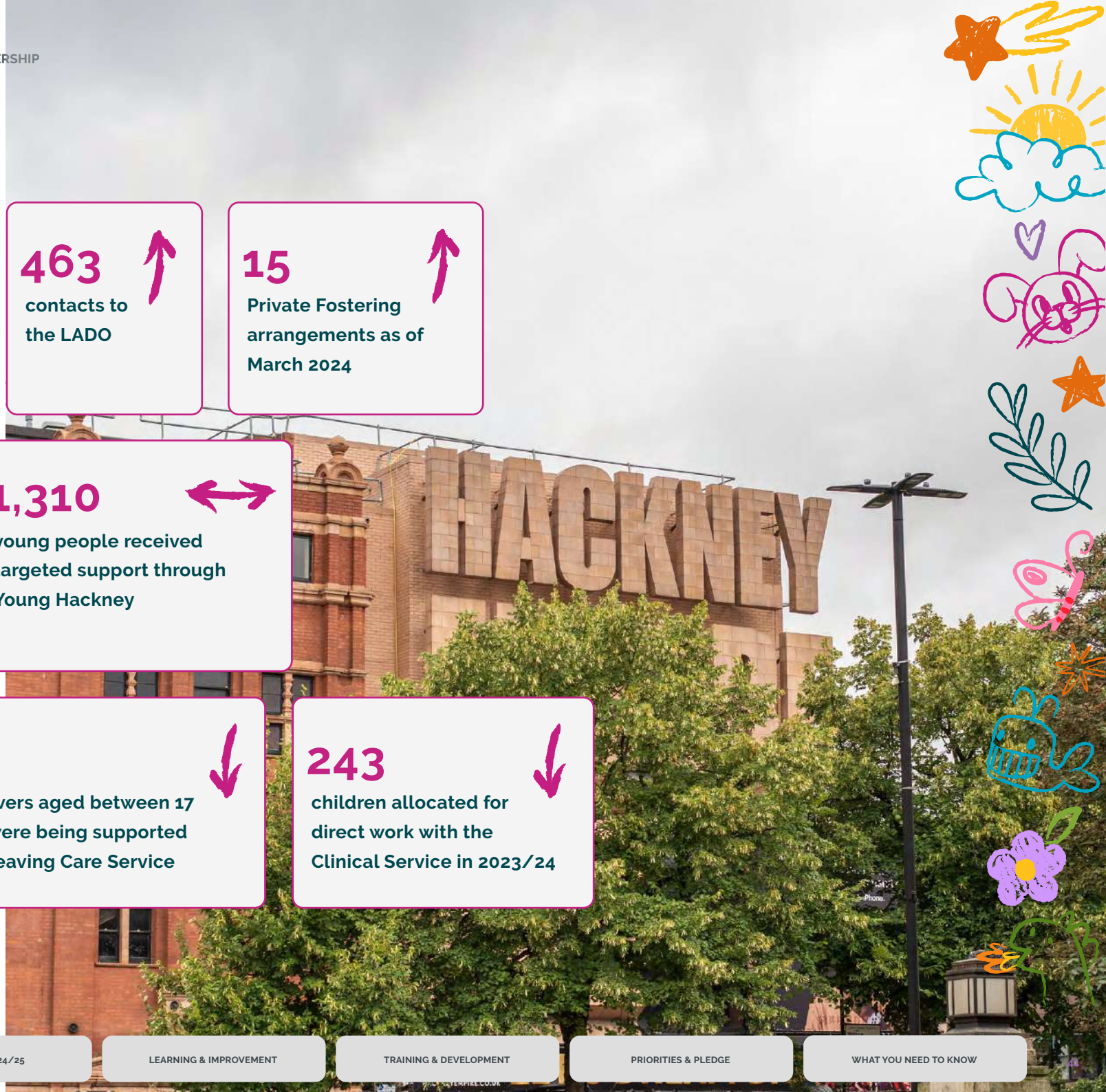
14,290
young people accessed universal services offered through Young Hackney

1,310
young people received targeted support through Young Hackney

133
children entered care during 2023/24

334
care leavers aged between 17 and 21 were being supported by the Leaving Care Service

243
children allocated for direct work with the Clinical Service in 2023/24



Safeguarding Partners & Relevant Agencies

During 2024/25, many agencies focused on strengthening their safeguarding frameworks and improving data management. The Met Police has addressed three causes of concern identified by HMICFRS, including improving its response to missing children and tackling victim-blaming language. They also launched a new "Child First" strategy, which aims to treat those under 18 as children first, identifying their vulnerabilities and understanding their circumstances. Similarly, the City of London Police has recruited new staff and improved processes for child sexual abuse material (CSAM) investigations. The East London Foundation Trust (ELFT) has a robust safeguarding governance framework and has improved its process for reporting referrals to Children's Social Care by mandating staff to complete an incident report form alongside any referral.

Numerous agencies have implemented new training and development initiatives. The City & Hackney Public Health Service has made children and adult level 1 safeguarding training mandatory for all staff. The National Probation Service has delivered updated training on safeguarding children and adults, as well as domestic violence, and has established stronger connections with specialist services.

Agencies are also making progress in service delivery and strategic planning. The City of London Children's Social Care and Early Help received an "Outstanding" Ofsted rating and has a stable workforce. Hackney Children and Families Service (CFS) also received a "Good" rating from its Ofsted inspection. Homerton Healthcare NHS Foundation Trust (HHFT) has developed new integrated pathways for Children's Occupational Therapy to improve patient safety and reduce risks. Additionally, Hackney CFS has opened a Care Leavers Hub and is planning to open internal Children's Homes.

Collaboration and a multi-agency approach are key themes in good practice. NHS NEL and its partners developed **a trauma-informed response** for child victims of domestic abuse, creating a guidance document with relevant resources for professionals. Agencies are also focusing on person-centred and holistic support, such as Homerton's Enhanced Health Visiting Service that is helping to identify early risk among vulnerable families.

Many agencies face **financial constraints** and workforce challenges. The Metropolitan Police Service has a £260 million budget deficit, which will lead to a reduction of approximately 1,700 staff, with the majority being officers. Hackney Council faces a financial challenge, needing to save £52 million over the next three years. Homerton Healthcare NHS Foundation Trust and other provider organisations face financial pressures to meet saving targets and are challenged by the ongoing recruitment difficulties for specialist children's roles.

There is also a growing concern about the **rising complexity of cases** and the gap between concerns and statutory thresholds. ELFT reports a sustained rise in emotional distress and self-harm among children and young people. The City of London Corporation Education and Skills Services noted an increase in children with social, emotional, and mental health (SEMH) issues, which has impacted school attendance. CAMHS teams across ELFT and HHFT are managing more complex cases involving a mix of mental health issues, exploitation, and neglect. Practitioners frequently find that these cases, while high-risk, fall below the thresholds for social care intervention, which creates ethical and clinical dilemmas.

Other challenges include **system-wide issues and new risks**. The loss of borough-wide forums, such as the Complex Case Forum, has led to some fragmentation in multi-agency working, with practitioners relying more on individual relationships to escalate concerns. The City of London Corporation Education and Skills Services highlighted challenges with adultification bias and digital safeguarding, noting that the evolution of digital platforms outstrips current frameworks. The National Probation Service and Hackney CFS also face staffing shortages and high turnover, which puts pressure on capacity and caseloads.

THE CITY OF LONDON CORPORATION - CHILDREN'S SOCIAL CARE AND EARLY HELP

EVIDENCE AND IMPACT

The Children's workforce has remained stable except for natural transitions and breaks such as maternity leave. Recruitment took place in 2024/25 to ensure that a permanent team is now in place. The workforce has now all completed the Achieving Best Evidence and Breakaway training; they have also accessed a range of training specifically around domestic abuse through the Court Trailblazers programme. All workers are supported to access Systemic Training and where required the Practice Educator training programmes. There is a comprehensive training programme in place as well as a well stocked resource library of research and direct work tools to support excellent practice which has positive outcomes for children. This was acknowledged in the 'Outstanding' Ofsted Inspection grading received during 2024/25.

Whilst numbers across the service have stayed relatively stable in relation to number of contacts, Early Help, Child Protection, there has been a reduction of the number of children remaining in care, although an increase in the numbers coming into care across the year. As most children in care in the City are unaccompanied asylum seekers, they arrive are accommodated and then placed on the National Transfer Scheme (NTS). The NTS has been working particularly quickly this year meaning some young people have been moving within 2-3 weeks of arriving. Which is positive for them as they are then able to settle in the Local Authority in which they will remain.

Child in Need numbers have decreased across the year this is in no small part due to the strong Early Help offer which provides a range of support at the earliest opportunity and prevents children and families requiring higher level support, which is positive. Thus, the number of children supported at home with their families overall remained consistent.

A well-developed Care Leaver Offer was launched which is accessible online and in a range of languages (Care Leaver Offer - City of London Family Information Service). Regularly monthly online drop-in sessions are offered to support care leavers to understand their rights and entitlements. Care leavers represent our largest cohort of young people accessing the service, with housing, immigration status, and employment being their top priorities.

We have continued to conduct an independent Annual Feedback Survey with broadly positive feedback received across all service areas. 83% of care leavers felt that their social worker was easy to contact and communicate with and 78% felt that the received the right amount of support. The Early Help received a 100% satisfaction rate. Children in Care and Child Protection numbers were very small with more variation in their views and experiences in terms of satisfaction; however the small cohort makes it difficult to draw definitive conclusions. We completed a 'You Said, We Did' response document to the feedback received and ensured that the feedback informed service development plans.

EVIDENCE AND LEARNING

We have consistently undertaken quality assurance practice reviews during the year, totalling thirty-nine reviews, to monitor the quality of practice and the impact on children and family's day to day experiences. None have been found to be 'Inadequate', 5 (13%) were graded as 'Requires Improvement', 15 (38%) were 'Good' and 19 (49%) were 'Outstanding'. Demonstrating that overall, the service provided is strong, where we have recommendations for improvement these are tracked on a monthly basis until we have implemented these and the impact then measured in future quality assurance activity.

IMPACT

CASE STUDY 1: *We had a baby under 1 years who was not previously known to City service present in an out of hours crisis. Police and out of hours services took immediate steps to ensure the safety of the baby, services then worked quickly to reunite baby and their parent in a safe assessment centre. Long and complex Care Proceedings were initiated, which were a challenge for the family to manage due their diagnosed additional needs and created feelings of hostility towards the social worker and service. However, the social worker and service worked persistently and tirelessly to continue to work with the family and support them to engage in the process. Sadly, the parent and baby were not able to remain together, however extensive work was done to explore extended family members to try and keep the baby within their family network. At times it did not feel like this would necessarily be viable however the social worker and service preserved and recently the baby was able to move to the care of a family member, with a package of support in place. This is the first use of our refreshed Kinship Support Offer (September 2024) which is in line with the best practice outlined in the Care Review. This is a plan that the parent has been able to give their consent to, recognising some of the issues which prevent them from providing sole care for her child. So far this is going well, and we are ensuring support is in place to try and sustain this arrangement.*

IMPACT

CASE STUDY 2: *An 8-year-old boy was referred to Early Help by a community outreach worker. The child had a disability from birth, but the family were not access disability benefits, and he was struggling in school. The family lacked confidence in navigating education or health systems due to language and cultural barriers. Once Early Help were involved they were able to support a referral to an Educational Psychologist for a comprehensive needs assessment, liaised with a specialist teacher to advise the school on appropriate adjustments, provided support for the family to apply for disability benefits, and an EHCP application was submitted to secure appropriate provision and prepare for secondary transition. The child now receives tuition and tailored classroom support, his family has increased financial stability and understanding of their child's condition, and he is more confident in learning and uses his aids consistently to support this.*

CHALLENGES

We have continued to focus on workforce stability and wellbeing, and whilst this has been good, we recognise the toll safeguarding work takes on individuals and teams. We have developed a Wellbeing Support Guide for People's Services which outlines a wide range of ways in which staff can promote their emotional and physical wellbeing.

This year we have started to define our Families in the City programme which will implement the National Social Care Review. Proposals were drafted and accepted by Senior Leaders which will lead to the creation of a Programme Board, under which three workstreams will work to deliver the changes needed. This will be established in 2025-26 and replace the current Senior Leader working group and include multi-agency partners. Whilst City already run a generic social work service there will need to be changes made and this may impact current roles and configurations which could lead to workers leaving or being dissatisfied with the new expectations.

Despite potential change we need to continue to deliver services to a high standard, which improves the daily experience and longer-term outcomes of our children, young people, and families, with minimal disruption. Therefore, communication with children, families, workers, and partners will be key to maintain consistency and limited confusion. The Quality Assurance service will also need to adapt as required to modified systems and ensure the framework meets the need of a newly modelled, multi-agency service. Workforce development will also need to be reviewed to ensure it is able to meet any gaps identified within the Families in the City programme in a timely manner.

THE CITY OF LONDON CORPORATION - EDUCATION AND EARLY YEARS

EVIDENCE AND IMPACT

Over the past academic year, City of London schools have embraced the Working Together to Improve School Attendance statutory guidance, updating policies and adopting a whole-school approach to promoting good attendance. In line with this, the City Code of Conduct was revised and, while no penalty notices were issued, eight 'Notice to Improve' letters were sent to parents. The Code will be reviewed annually, with minor updates planned to improve clarity and referral processes.

The School Attendance Support Team has maintained strong engagement with all schools, conducting regular visits and hosting two successful School Attendance Network meetings. These meetings, including input from DfE Advisor Victoria Franklin, highlighted the shared responsibility for attendance and the vital role of Attendance Officers. The DfE has assessed the City of London's arrangements as 'Green'. A termly newsletter will now keep schools informed of updates, training, and local data.

Using data from the school tracker, which currently monitors City-resident children across 68 schools in 20 local authorities, the team has identified and contacted out-of-borough schools with persistently absent pupils. Schools have been reminded that the team is available to support families in overcoming attendance barriers. To ensure a clear picture of where City children are educated, the school tracker has been updated to include those in alternative provision and with SEND, helping to anticipate needs and guide support.

The restructured Attendance Improvement Group—formerly the Vulnerable Children group—meets termly and includes representatives from education, social care, and the Virtual School. It ensures early identification of concerns and coordinated support for re-engagement with education. Recognising that poor attendance can impact a child's potential and safety, termly Education Safeguarding Forums have provided a platform for schools, the local authority, and CHSCP to share best practices. External services such as Prevent and the City & Hackney Substance Use Service have also contributed. The School Attendance Support Team continues to offer timely signposting and referrals to relevant agencies. For example, following the Inclusive Charter conference, a referral was made to Fight for Peace—a programme using boxing to re-engage a school refuser with SEND. Finally, the newly established Network Attendance Meeting brings together DSLs and attendance leads to share strategies, raise concerns, and collaborate on improving attendance outcomes.

IMPACT

CASE STUDY 1: *A Year 8 pupil with a diagnosis of Autism Spectrum Condition (ASC) came to the attention of the City of London SEND Team due to escalating behavioural concerns in school. Although the pupil had a confirmed diagnosis of ASC, their needs were not being adequately supported, and they were at risk of permanent exclusion. This risk materialised in January 2025, just before the finalisation of their Education, Health and Care (EHC) Plan.*

The SEND Team worked closely with Early Help Support Services to ensure both the pupil's social and special educational needs were identified and addressed. Interim tuition through an alternative provision provided some initial stability while a longer-term solution was sought. Through persistent advocacy and collaboration with a neighbouring borough, a place was secured at an Autism Resource Provision (ARP) within a mainstream secondary school.

A robust transition plan was co-produced by SEND, Early Help, the family, and professionals from both the alternative provision and the ARP. This ensured a phased and well-supported entry into the new setting. Since joining the ARP, the pupil has shown marked improvement in emotional regulation and engagement with learning. While some behaviours linked to anxiety and ASC continue to present, the school is well-equipped and skilled in supporting these needs. The family now has a secure and coordinated network of professionals around them, able to adapt provision as needed to give the pupil every best chance of success. The pupil's progress is being closely monitored to ensure their needs are met holistically. This case highlights the importance of early support following diagnosis, cross-agency collaboration, and the value of specialist provision in enabling pupils with complex needs to re-engage with education and thrive.

IMPACT

CASE STUDY 2: *With reference to one of the City of London schools, concerns were raised by the school of a year 10 pupil arriving persistently late frequently, arriving after registration closure.*
The Education Welfare Manager supported a meeting with parent and the pupil to understand the root cause of poor routine and disengagement with learning. An Early Help referral was made by the Education Welfare Manager, with the consent of parent.
Close parental engagement work was carried out from a Family Practitioner to support the relationship between the young person and their parent.
The school noticed an improvement in punctuality and learning engagement and continues to be supportive through praise and regular check-ins with parent and pupil.

EVIDENCE AND IMPACT

SEND - SEND is always a priority and the Service, along with the area partnership is committed to ensuring that *The City of London is a place where children and young people feel safe, have good mental health and wellbeing, fulfil their potential and are ready for adulthood whilst growing up with a sense of belonging*. We remain committed to high aspirations for all our children and young people, ensuring they receive an education tailored to their individual needs, along with the appropriate support to help them reach their full potential.

In line with national trends, we have continued to experience a rise in the number of Education, Health and Care (EHC) Plans over the past year, leading to increased demands on the SEND team. The SEND Team has increased capacity through an additional EHC Caseworker to support this increased demand. The City of London has also agreed a contract with the Hackney Educational Psychology Service to offer a bespoke package of support for City children and young people with SEND. There has been an increase in need in children coming through in the early years, and an increase in social, emotional and mental health issues in children coming though in KS3. Where there has been an increase in social, emotional and mental health needs, this has impacted on school attendance and one permanent exclusion. The SEND team has worked closely with the Education Welfare Manager and Children's Social Care and Early Help Service to regularly monitor and support these young people.

The City of London actively participates in every annual review to maintain oversight of any emerging developments and to ensure families are signposted to relevant services or referred as needed. Several children and young people with EHC Plans are also supported by children's social care and early help services, prompting close collaboration between the SEND team and social workers to ensure a coordinated and integrated approach. The SEND team also attends meetings arranged by the Children's Social Care and Early Help Service such as CIN meetings and TAF meetings to ensure a coordinated approach to meeting these children's needs.

EVIDENCE AND IMPACT

Early Years - The Early Years Advisor undertakes yearly Leadership and Management audits in the Autumn Term. These include key questions on safeguarding and ensure early years settings continue to be compliant with regulations. The Early Years Foundation Stage (EYFS) framework, which outlines safeguarding requirements for children under five, has had some clarifications. Changes include amendments to staff-to-child ratios, clearer guidance on paediatric first aid training and the importance of ensuring adequate supervision, especially when children are eating. Effective from September 2025, the Department for Education (DfE) is implementing significant reforms to the EYFS safeguarding requirements to ensure that early years providers maintain high standards of safety and care for children. These reforms are based on extensive consultations and feedback from stakeholders in the early years sector. The Early Years Team continues to work closely with the Early Help Team, particularly when children with additional needs are concerned as well as on the development of the Start for Life and Family Hub. All City Early Years settings remain Good or Outstanding with Ofsted.

EVIDENCE AND IMPACT

Adult Education and Skills - The adult skills service reviews termly all learners' continued understanding of Safeguarding. Important emphasis is placed on safeguarding themselves and others. 'Good Safeguarding' practice is fully incorporated in the subject course curriculum – it therefore becomes an integral part of teaching and learning. Learners are given an induction on the importance and value of understanding 'good Safeguarding'. All course tutors receive level 2 certificated training in understanding Safeguarding. The Service employs 3 Safeguarding Leads – they also receive certificated training. All learners are regularly/ termly asked about their understanding of Safeguarding. Their responses are recorded, analysed and an action plan is put in place to support any areas for further development. Learners are advised how to report breaches in Safeguarding practices - they are advised on the role of the Safeguarding Leads, and how to report issues and concerns. Monthly meetings are held with the DCCS Safeguarding Lead/ Adviser. Focus on Apprentices.

THE CITY OF LONDON POLICE

EVIDENCE

There have been several *Operation Makesafe* deployments across the City of London designed to test the response of hotels to possible child sexual exploitation and educate them as how to best respond to protect children and young people. The CoLP Public Protection Unit have benefited by the recruitment of an experienced Child Protection Detective Inspector and have created a further Detective Sergeants post to assist with partnership working and coordinating safeguarding across the force. The Public Protection Unit has reviewed and improved the processes around Child Sexual Abuse Material (CSAM) Investigations ensuring compliance with national best practice and welfare support for investigating officers.

EVIDENCE

A recruitment process was held for a new Detective Inspector in the Public Protection Unit. This was extremely competitive, and a new appointment was successful. The post-holder brings a wealth of experience with him as he was previously a DI in a child abuse team. The force is subject to a HMICFRS inspection and as part of this, a review of the PPU was conducted including Child Abuse Investigation and the management of Registered Sex Offenders. Once the feedback is received the CHSCP will be updated in respect relevant findings.

IMPACT

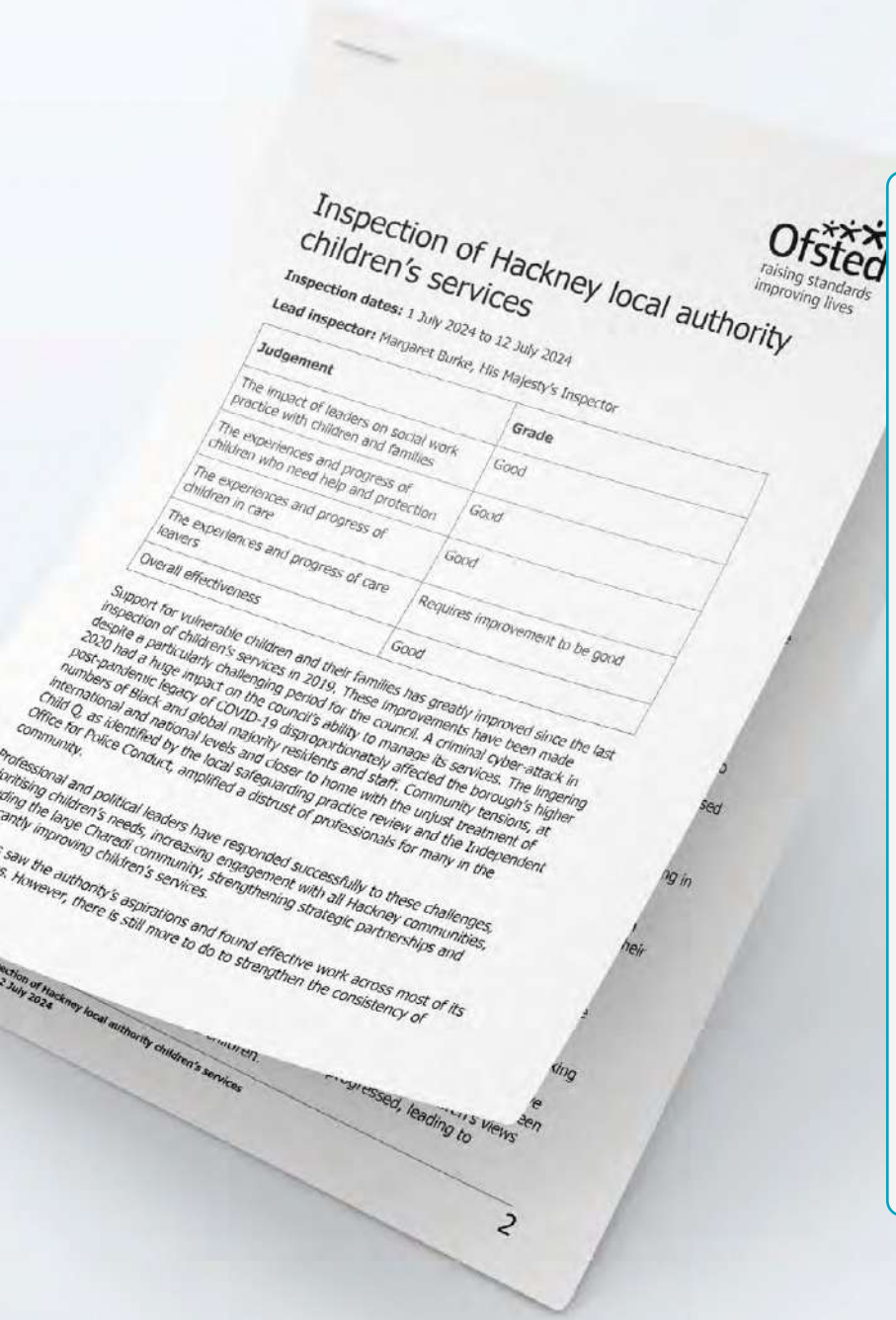
CASE STUDY 1: *PPU have an ongoing case where a young female travelled into the City with a friend and was able to get served alcohol in a licensed premises. She became intoxicated, separated from her friend and was then befriended by a male who subsequently seriously sexually assaulted her. She had no memory of the assault. Detailed forensic work has identified the offender, and he has subsequently been charged. Alongside this, colleagues in licencing are now seeking to prosecute the licenced premise that served the victim alcohol.*

LEARNING

The CoLP have requested that the Vulnerability Knowledge and Practice Programme (VKPP) come and perform an inspection of how the force deals with vulnerability in children and young people. The VKPP is part of the College of Policing which sets out best practice nationally. The review was not requested as the result of any incident or organisational failure but rather as an opportunity to obtain feedback and seek to improve.

IMPACT

Further engagement work was completed by CoLP during the recent County Lines Intensification Week (CLIW) which included Officers attended high-end retailers within the Square Mile to raise awareness of how children exposed to CSE may be bought gifts as part of the grooming process into County Lines. This was also well received and further education was requested. During CLIW, six hotels in the City were also tested. Only one hotel passed by appropriately dealing with a child being checked in with an adult that appeared to be unknown to them. Following this, education pieces will be rolled out to hotel management to upskill staff to spot signs and disrupt where possible.


Inspection of Hackney local authority children's services

Ofsted
raising standards
improving lives

Inspection dates: 1 July 2024 to 12 July 2024

Lead inspector: Margaret Burke, His Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experiences and progress of children in care	Good
The experiences and progress of care leavers	Requires improvement to be good
Overall effectiveness	Good

Support for vulnerable children and their families has greatly improved since the last inspection of children's services in 2019. These improvements have been made despite a particularly challenging period for the council. A criminal cyber-attack in 2020 had a huge impact on the council's ability to manage its services. The lingering post-pandemic legacy of COVID-19 disproportionately affected the borough's higher numbers of Black and global majority residents and staff. Community tensions, at international and national levels and closer to home with the unjust treatment of Child Q, as identified by the local safeguarding practice review and the Independent Office for Police Conduct, amplified a distrust of professionals for many in the community.

Professional and political leaders have responded successfully to these challenges, prioritising children's needs, increasing engagement with all Hackney communities, including the large Charedi community, strengthening strategic partnerships and significantly improving children's services.

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HACKNEY COUNCIL - CHILDREN & FAMILIES SERVICES

EVIDENCE

The most recent inspection of children's services in Hackney was published in August 2024. This graded the overall effectiveness of the Local Authority as Good. The report can be read HERE.

Inspectors said: *"Support for vulnerable children and their families has greatly improved since the last inspection of children's services in 2019. These improvements have been made despite a particularly challenging period for the council. A criminal cyber-attack in 2020 had a huge impact on the council's ability to manage its services. The lingering post-pandemic legacy of COVID-19 disproportionately affected the borough's higher numbers of Black and global majority residents and staff. Community tensions, at international and national levels and closer to home with the unjust treatment of Child Q, as identified by the local safeguarding practice review and the Independent Office for Police Conduct, amplified a distrust of professionals for many in the community. Professional and political leaders have responded successfully to these challenges, prioritising children's needs, increasing engagement with all Hackney communities, including the large Charedi community, strengthening strategic partnerships and significantly improving children's services. Inspectors saw the authority's aspirations and found effective work across most of its service areas. However, there is still more to do to strengthen the consistency of support to care leavers and to secure good-quality and stable accommodation for them at the time they need it."* ***Ofsted 2024***

EVIDENCE AND IMPACT

The restructure of the management levels within Children's Social Care concluded in January 2025. The restructure has simplified the service structure, providing clearer management structure and lines of accountability. The new structure includes a move away from the unit model towards a traditional social work team model, with Consultant Social Workers and Practice Development Managers have been replaced by Team Managers and Practice Leads. Separate to the management review - the Multi Agency Safeguarding Hub (MASH) completed a staffing review in the spring of 2025. The MASH has aligned its management structure with the wider CFS, incorporated EDT line management to the structure, and ensured permanency for the MASH Early Help Hub.

Our in-house Clinical Service is undergoing a restructure. The clinical restructure has meant we are no longer delivering clinical interventions that would elsewhere be the responsibility of CAMHS. There is also a Business Support Review which was launched in July 2025, which is looking at the structure of our business support functions. Furthermore, the Young Hackney service has undergone a restructure. The Young Hackney restructure has refocused the age profile of those supported by the service towards adolescents aged 10 – 19 and developed a locality model on a smaller defined geography, including 4 area teams. Further organisational change is likely to occur in areas such as the Family Support Service as the Directorate responds to the Social Care Reforms.

EVIDENCE

Plans are underway to open internal Children's Homes, to promote Children in Care living within our borough. Feedback from the pre-planning application has been received, and planning applications are set to be submitted. A new Commissioning Officer has started as Project Manager adding additional capacity and expertise to drive the programme forward. Work to recruit young people to co-produce the final design and finish of the buildings, as well as procure the expert service partner to run the homes and support commissioners to monitor the quality of the homes when they are set up, is underway.

LEARNING

Learning Conversations: *Between February and April 2025,* a total of 15 learning conversations were carried out on children's files. These conversations focused on Parental Metal Health. 53% of cases were rated as being good, 40%, were found to require improvement, and 1.7% judged to be inadequate. Good practice included inclusion and promotion of children's voices in their plans, good plan progression, good multi agency support for children, good management oversight for children supported by legal proceedings, Looked After Child and Child Protection plans, and good curiosity around children's identity needs.

LEARNING AND IMPACT

Practice Observation Week. In June 2025, Hackney CFS launched a Practice Observation Week, where leaders including Team Managers, Service Managers, Heads of Service, the Director and Group Director completed observations of direct practice. The purpose of this was to provide feedback to practitioners on their practice and to enable managers to experience the quality of practice across our services to children and their families. Highlights included:

> One observer felt that the social worker 'clearly demonstrated an effective use of communication with the child. He was curious about what they had said and their experience, including of having multiple social workers come into their life. He was able to take time to explore what they thought about the situation and what might make things better for their family'.

> One observer commented on swift MASH procedures, 'the decision making is very effective and timely - following the conclusion of the telephone call - [the social worker] is recording and processing the information without delay - and a MASH manager is subsequently making the decision to progress the contact for assessment. The whole process is concluded within 45 minutes of the call coming through'.

> Observing a Young Carers Group, the observer commented that 'the voices of all young people are being heard within session, the communication helps to facilitate learning. The views and suggestions are taken on board. The young people expressed how much they enjoyed being part of this group and the positive experiences that they have had at the Young Carers'.

> One family shared that the social worker 'genuinely listens which is helpful, they haven't always felt listened to by social workers but do with [the social worker]', and another stating the social worker has 'consistently been efficient, communicative, and very easy to work with. Her dedication and professionalism have been evident throughout, and we are genuinely grateful for her continued support over the years.'

IMPROVEMENT

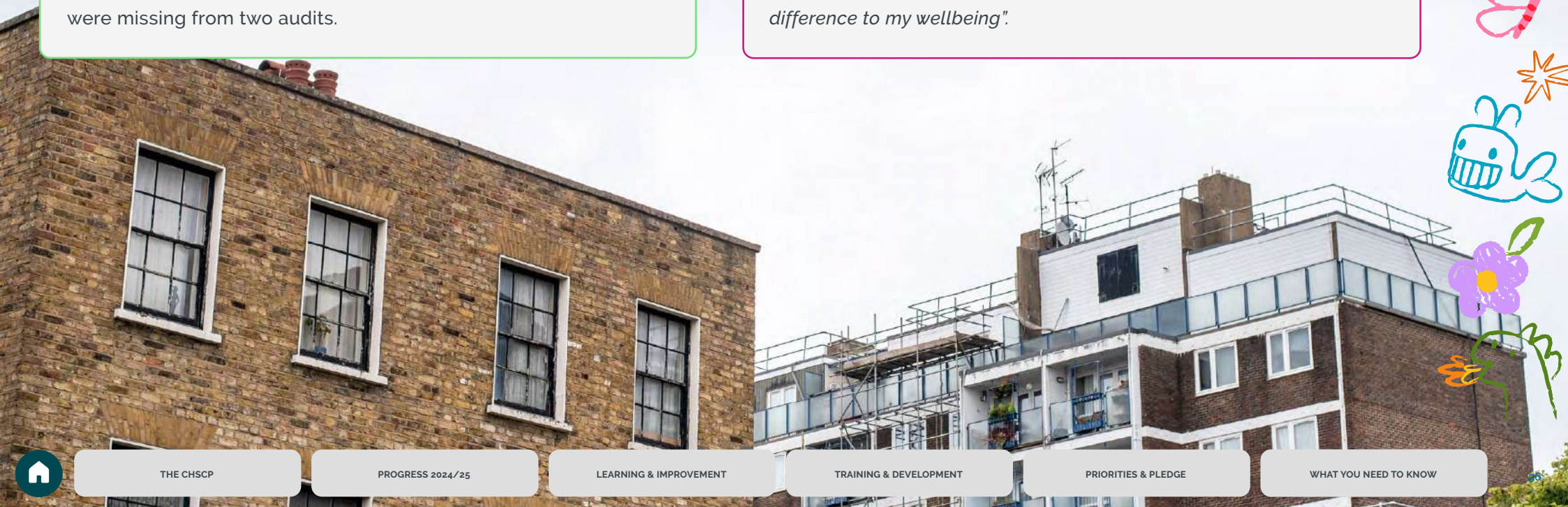
In May 2024, Practice Development Managers reviewed 11 full audits undertaken in HCFS that were initially graded as Inadequate or Requires Improvement. The purpose was to re-evaluate these cases and identify any improvements in practice. The findings showed significant progress, with practice improving to Good in over half (58%) of the reviewed files. Notably, two cases that were previously graded as Requires Improvement were now considered Good. None of the cases remained at the Inadequate level. The review also highlighted improvements in timely and detailed recording, and it was noted that identified actions were either completed or in progress. However, some areas for improvement were still identified, including instances where visits and recordings were outside of set timescales and meeting minutes were missing from two audits.

IMPACT

A parent or carer working with the Family Support Service shared: *"I really want to say a huge thank you for all the support and guidance you've given me. Your help has made such a difference in getting [Child] back on track and I feel so much more confident as a parent because of you".*

A parent or carer working with Young Hackney shared: *"Thank you so much for your work with [Child], it has made a huge difference and you have helped them through a very difficult time and they have come out confident and happy on the other side".*

A parent or carer working with the Multi-Agency Safeguarding Hub shared: *"Your kindness, expertise and sensitivity...made a huge difference to my wellbeing".*



CHALLENGES

Financial Pressures: In Hackney, we are facing ongoing pressures of service demand and tightening of funding. This is due to increasing costs, growing demand and a lack of clarity about long-term funding arrangements. As a council, we have to save £52m over the next 3 years. Therefore, there will be an action plan to reduce expenditure within each Directorate. Due to this, the provisions currently on offer will be under review, and future provisions may change.

As the cost-of-living crisis continues, Hackney families continue to face poverty, homelessness and hunger. Thus, supporting families with the cost of living at the earliest stage possible is of key importance. Hackney Council is undertaking a range of activity in response to this crisis, including the adoption of the Poverty Reduction Strategy 2022-2026.

Workforce: Nationally there continues to be high staff turnover, and challenges in recruiting and retaining social workers, resulting in high caseloads. Where we have recruited staff, they may be less experienced and require increased support from managers to ensure high-quality practice. We have implemented several incentives to recruit and retain staff.

Care Leaver Accommodation: During our 2024 inspection, the key message once again from our young people, echoed by inspectors, was that for care leavers, access to safe, affordable, sustainable housing is their number one priority. We have established a sub-group of the Corporate Parenting Board, Chaired by the Group Director for Climate, Homes and Economy, to track the progress and monitor outcomes of this work over the next year. The most significant development has been the decision - endorsed by Cabinet - that the Housing Register would be amended from April 2024 to enable care leavers to join in a priority band from 18. Work is underway to support all care leavers who wish to do so to join the register. Housing colleagues have backdated all existing application start dates for care leavers to their 18th birthdays. We hope in time that this will mean fewer care leavers experience a 'cliff edge' in their housing options at 21 and more are able to secure social housing tenancies - should they wish to do so - in a timely way.

We were delighted to secure Department for Levelling Up, Housing and Communities' funding early this year for a Housing First project, through which 10 care leavers with the most complex needs will be offered a tenancy alongside intensive, wrap-around support from Centre Point. Through this joint Children's Social Care and Housing project, we hope to learn more about how best to offer post tenancy support to our care leavers. This learning will inform an update of our Joint Protocol, which will include a new focus on post tenancy support, including repairs and maintenance.

HACKNEY EDUCATION

EVIDENCE

Hackney Education's mission is to improve the life chances of every child in Hackney by creating a safe, inclusive, and exciting educational environment. The organisation is aligned with Hackney Council's corporate values, these are: child and learner focused, ambitious, proactive, inclusive, pioneering, open, and proud. These values guide the organisation's approach to its objectives. A significant focus of Hackney Education's Improvement plan is safeguarding children and addressing systemic racism. Priority (A) is dedicated to ensuring that all schools are, and feel, completely safe and free from racism, building on the report into the experience of "Child Q". Key initiatives include:

- Introducing a "Hackney safe and inclusive schools charter".
- Taking rapid action on the presence of police in schools..
- Sustaining action on anti-racism and providing professional development for staff to be anti-racist.
- Ensuring the voices of children, parents, and staff are heard.

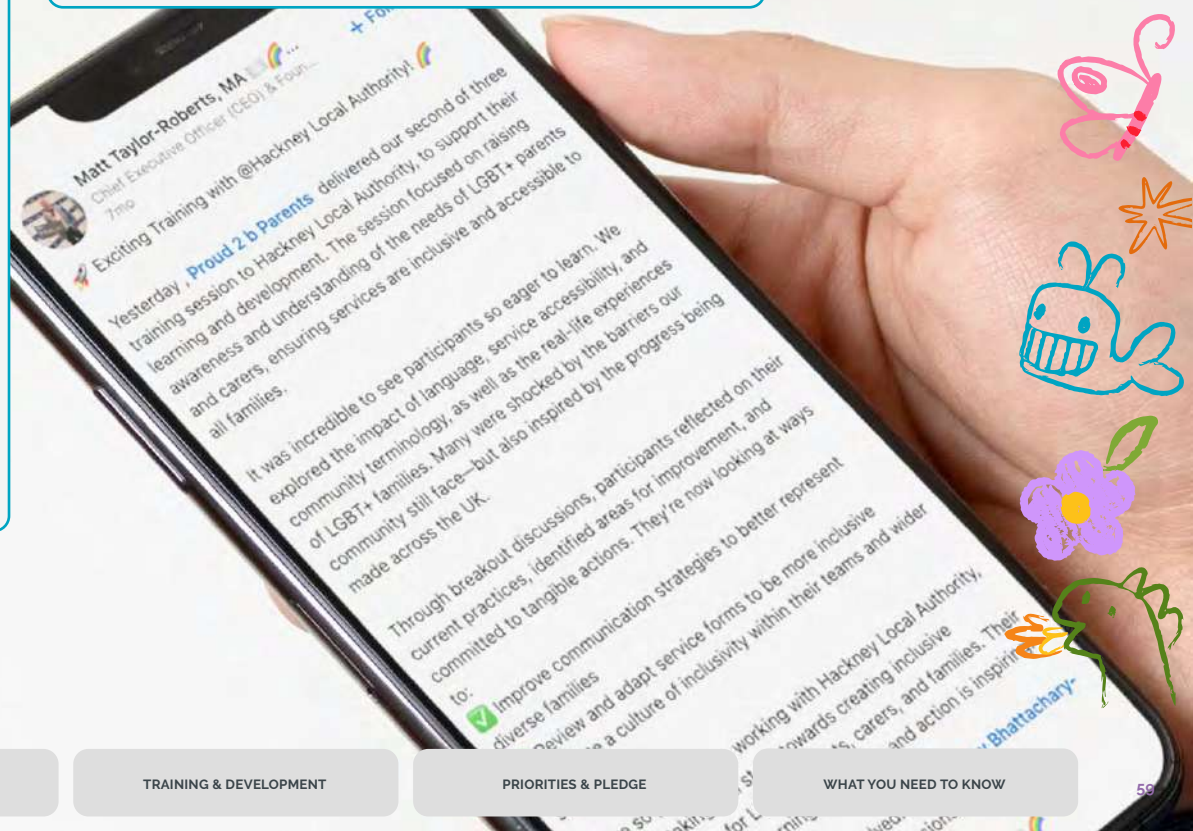
EVIDENCE

During this reporting period, Hackney Education had five main priorities:

- **Priority 1:** Achievement: Working with schools and settings to enable the best possible achievement for every child, with a focus on closing achievement gaps for pupils receiving pupil premium, Turkish Kurdish Cypriot pupils, Caribbean pupils (boys), and Orthodox Jewish pupils.
- **Priority 2:** Wellbeing and Inclusion: Promoting safeguarding, wellbeing, and inclusion, including provision for children with Special Educational Needs and Disabilities (SEND), reducing exclusions, anti-racism, and post-COVID recovery.
- **Priority 3:** Quality Places: Providing quality educational places for every child from age 0 to 19, including implementing a school place strategy and transforming children's centres.
- **Priority 4:** Strong and Sustainable System: Ensuring the Hackney education system remains strong, sustainable, local, and responsive to enable high performance in all schools and settings.
- **Priority 5:** Supporting Parents: Supporting and engaging parents and carers by ensuring their voices are heard and providing support routes for those experiencing difficulties.

EVIDENCE AND IMPROVEMENT

Children and Family Hubs have moved to a neighbourhood model, based on eight primary care neighbourhoods aligned with Children's Centres. SEND Hubs, Super Youth Hubs, Child in Need teams and Family Support teams will also be aligned according to this neighbourhood model. After the final Children and Family Hub was launched at Woodberry Down on 27 February 2025, new programmes have been commissioned, including the WellComm Tool, Proud to B Parents Training, and an Outreach Strategy with HCVS.



EVIDENCE AND IMPROVEMENT

Improving school attendance is a priority nationally in education, and Hackney has developed a School Attendance Support Team to respond to the barriers to education that schools and families are experiencing. As part of this work, we have extended our offer beyond maintained and academised schools, to include the Charedi independent schools operating in Hackney. These schools serve children who identify as Charedi in Hackney, which is a rapidly growing percentage of our overall school-aged population. The work has focused on developing a culturally informed programme of support, and forming positive relationships through which we can jointly leverage change and positive impact for the children we serve. Hackney Education has one attendance officer dedicated to supporting just our Charedi schools around attendance barriers, the consistency of which has really helped to strengthen the relationship and quality of the work undertaken.

We have provided ongoing training to education professionals in the Charedi community that is accessible and culturally informed (for instance, we run face to face sessions as well as online sessions, and attendees can choose between sessions run by either a male colleague or a female one). In order to demonstrate our commitment to understanding and serving our Charedi independent schools, we have broadened our attendance training offer to include all Charedi independent schools in the UK. We have welcomed Charedi education colleagues from Manchester, Salford and Gateshead into our Hackney-based training sessions. One session which we ran online was attended by 86 rabbis. We continue to offer guidance and oversight around attendance policies and approaches and are working with around 70% of our Charedi independent schools, and we look forward to developing this work further and with more settings in the new academic year.

EVIDENCE AND IMPACT

- To help children and families cope with the cost-of-living crisis, the following support is available.
- Free school meals: All children starting school in the reception class, Year 1, or Year 2 will get a free meal at school regardless of income.
- Children and families 0-19: Children receiving free school meals or those identified by local providers in the statutory, voluntary and community sector or Children's Centres (including the Orthodox Jewish community) and in local colleges have been provided with food vouchers. School uniform grants are also available from Hackney Education for families who are struggling to afford this.
- Hackney provides funded 2 year nursery places, now open to families with no recourse to public funds.
- Early Help hub and Multi-Agency Safeguarding hub: Families contacting the Early Help hub or professionals making contact on the MASH consultation line on behalf of families in crisis may be referred to community support, including children's centres, youth hubs or community partners, and families may be provided with food vouchers in an emergency.
- Children and families hubs: Families receiving targeted support via the Multi-agency teams (MAT) receive food vouchers, and all other families who are eligible can access Healthy Start vouchers and Alexander Rose vouchers, redeemable for fruit and veg from Hackney markets.
- Youth hubs and adventure playgrounds/ holiday activities: Free after school and holiday activities are provided to families via youth hubs and adventure playgrounds.
- Voluntary and community sector support for under 5's: Voluntary and community groups who support families in need across the borough have been provided with funds to purchase food vouchers to distribute, and a number of these are accepting referrals from other VCS groups.
- Emergency funds remaining for children in need: emergency funding for food vouchers has been identified to support care leavers, families supported by Child in Need, Child Protection and Family Support plans, and in-house foster carers.
- Section 17 Finance Guidance for CFS Staff: A guidance document produced to assist practitioners in the work they do with and for families when children's identified needs require the provision of financial assistance.

IMPACT

This year also saw 100% of our schools and children's centres receive good or better Ofsted judgements in all of the graded areas of inspection.

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CHALLENGES

It has been a challenging year for many of our communities facing the closure of their schools due to declining pupil numbers. Particularly, it has been painful to see the closure of four wonderful schools who have provided the best possible education for their families: We thank and recognise the staff leaving the following schools which are closing at the end of the academic year 2025.

- Oldhill Community School (whose pupil body is merging with Harrington Hill School)
- St Dominic's RC Primary School
- St Mary's C of E School
- Sir Thomas Abney Primary School (whose pupil body is merging with Holmleigh School and will be located on the Sir Thomas Abney site)

CHALLENGES

A consultation on the Strategic Plan for 25-28 began in the Autumn of 2024. In order to tackle some of these challenges, several key priorities were identified. These were:

Special Educational Needs and Disabilities (SEND) and inclusion: Ensuring efficient and sustainable SEND provision, early identification of needs, and timely support.

Additional and Alternative Learning Provision: Developing a three-tiered support model to promote inclusion, reduce exclusions, and ensure appropriate interventions.

Strength and sustainability: Ensuring schools, children's centers, and settings are strong, sustainable, and financially viable, with a focus on recruitment and retention of staff.

Sustainable school improvement: Delivering a successful, affordable, and sustainable local education system by promoting collaboration, sharing best practices, and supporting innovation.

Equity for children and families: Working to achieve the best outcomes for all children, particularly focusing on ensuring equitable opportunities and targeted support for those who need it most to thrive.

Outreach and engagement activities will continue into the 25/26 period.

YOUNG HACKNEY

EVIDENCE

Young Hackney successfully re-structured in 2024 in response to local savings targets. The new iteration of the service went live in April 2025. The integrated model and approach to service delivery largely remains the same and there have been no changes to play, young carers, health and wellbeing and substance misuse services. However, the service is now operating with a more streamlined and targeted capacity and is focusing the Young Hackney offer at adolescents more specifically. Key changes include; a revised aged criteria for universal youth services and targeted early help of 10-19 (25 with SEND), the introduction of a medium/ high early help need threshold for individual targeted early help, earlier and longer opening hours for teenagers at our youth hubs and the establishment of a dedicated Young Hackney Detached Outreach Team.

Since the re-structure Young Hackney has started to receive fewer 'Requests for Help', this is consistent with expectations as the service manages demand under new arrangements, however patterns regarding type of need, referral source and interventions offered remain consistent.

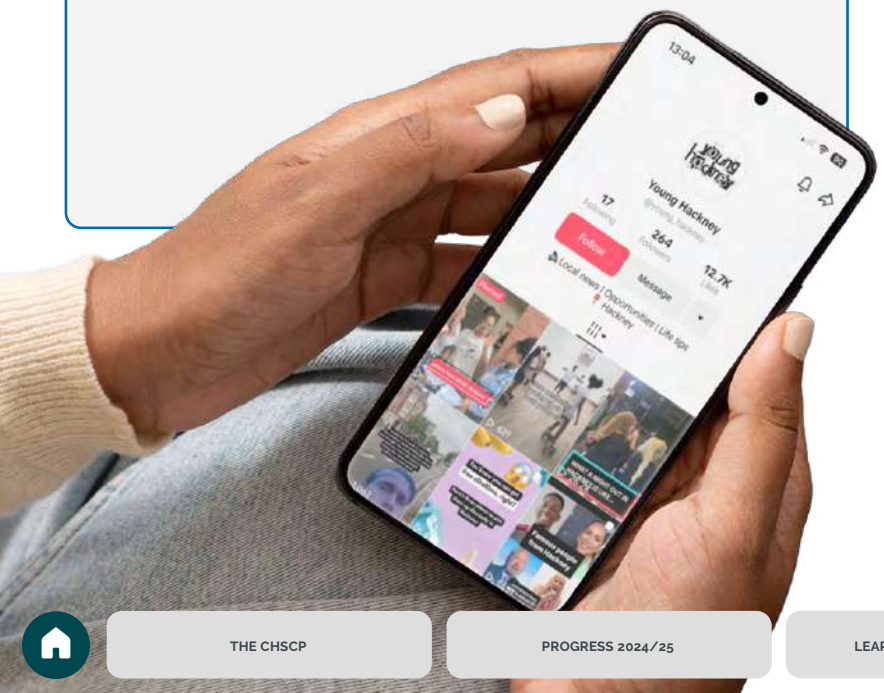
Health Spot City and Hackney at Forest Road Youth Hub- the young people's health initiative led by the CAMHS Alliance and Young Hackney that brings a broad range of health services to young people and supports access with youth workers continues to grow and develop.

LEARNING

Young Hackney is refreshing some foundational training for its staff and beginning to expand this offer to commissioned VCS youth providers with a first cohort of practitioners recently completing 'An Introduction to Systemic Practice' and Trauma Informed Care training with the Tavistock and Portman NHS and second cohort pending.

EVIDENCE AND IMPROVEMENT

Young Hackney is now on TikTok: @young_hackney. Early indications suggest the social media platform will offer a significantly broader digital communication reach for the service to young people.



IMPACT

Referred by school to Young Hackney's Young Carers Service in December 2024. Mum has Type 1 Diabetes and her health had deteriorated in recent years resulting in a period of hospitalisation. IS-L was providing practical, personal and emotional care for mum. School were concerned about the impact IS-L's caring responsibilities were having on his emotional wellbeing and difficulties in school. The family were isolated, both mum and IS-L had little support beyond each other. The YH Young Carers Team quickly engaged the family, forming strong relationships with both IS-L and his mum. IS-L was offered six individual support sessions and access to a range of activities for young carers. Mum was anxious about IS-L leaving the home and engaging in extracurricular activities but was reassured with support to allow IS-L to start attending young carers swimming lessons which eventually lead to mum attending her own fitness classes on the same site. Soon the family were taking part in a range of leisure and fitness activities independently and together helping to address their isolation and mum's health needs.

During the course of the intervention IS-L disclosed experiences of racism in school by a teacher. The Young Carers Team addressed this with school who responded appropriately, IS-L and Mum reported a significant change in IS-L's experience in school thereafter. Mum is better managing her health needs now, her independence and confidence is returning and IS-L's caring responsibilities have become more manageable. Mum said *'The service has helped us in many ways. I feel like it's an extended family that I can rely on. With so much support it's brought balance and security'... 'After the 1:1 sessions IS-L comes back feeling 'full', it's like a reset for him'...'It's provided hope of getting back to normal'*

IMPACT

A young person was referred to Young Hackney for Targeted Early Help by the police via the MASH in February 2025 following a missing episode after getting in trouble at school. At the point of referral parents also shared concerns that they had found a knife under the young person's pillow, and that the young person was worried that peers had threatened to attack them in their home. Whilst doing academically well, the young person experienced bullying and had no friends.

The allocated Young Hackney worker formed a trusted relationship with both the young person and family and quickly hypothesised that they may have an undiagnosed/ unmet learning need that was affecting social skills, interactions and experiences. This was a very sensitive matter for the young person and family who were reluctant to engage in this discussion. The Young Hackney worker tactfully addressed the matter enabling the family to eventually disclose that the young person has a lifelong neurological condition that would explain their difficulties. Due to mistrust, the family had never wanted to share this diagnosis with school or other professionals, had been managing this on their own for most of their child's life and they thought that because they were doing well academically, their condition was not the cause of her current difficulties. The Young Hackney worker helped the family to understand the impact of the condition on social skills and relationships and with reassurance they consented to this information being shared with a trusted adult in school so that the appropriate support could be put in place. The school was supportive and despite there still being some difficulties the family have reported significant improvements in circumstances.

CHALLENGES

Young Hackney has been through considerable change this year, there may be challenges as these changes continue to take effect and we begin to see possible consequences- managing demand for individual targeted early help or school-based interventions for example. It will be important that we continue to work closely with partners- particularly school and health and the MASH to collaboratively meet early help need.

HACKNEY YOUTH JUSTICE SERVICE

EVIDENCE

The new 2025-2028 Youth Justice Service Strategic Partnership Plan was approved by Full Council in July 2025, as required as a condition of our YJB grant. To develop the Youth Justice plan 2025-28 the Safer Young Hackney Board came together in a facilitated workshop to consider our local performance data, the outcomes we achieve for children, the challenges we are now facing, feedback from children and families and the progress made. Collectively the Board agreed our shared practice principles and approaches and the shared key objectives for the next three years.

The plan outlines Hackney's partnership vision for children who are engaged with, or at risk of entering the Youth Justice System. It emphasises safeguarding, prevention, early intervention, and responding to local needs. It highlights the partnership's shared commitment to a "child first" and strength-based approach which is aligned with our Hackney STAR-R model (Systemic, Trauma Informed, Anti Racist and Restorative). The document includes the partnership's anti-racism position statement, acknowledging systemic racism and committing to practice which is anti-racist and actively champions social justice.

EVIDENCE AND IMPROVEMENT

Safer Young Hackney Board continues to be well attended and effective.

The Youth Justice Integrated Health Team (Health Huddle) continues to be embedded as part of the Hackney Youth Justice Service. This health team includes the Youth Justice Service Lead Nurse, Speech and Language Therapy Service, Clinical Team, Specialist CAMHS, Substance Misuse Service, and Sexual Health Nursing Service.

Our SALT team have been commended for their work in court with positive feedback from magistrates, defence solicitors and parents.

ETE - Recruitment for an additional Virtual School member to support children on both Out of Court Disposals and Bail Support is now complete - This was required as an outcome of inspection.

P&D/ MPS Stop & Search information initiative (QR code) with a video developed by young people which brought the information to life.

IMPACT

Parent: *Felt fully involved in her child's YJS work noting her child was "challenged" by his YJS practitioner in a way that prompted her to reassess her parenting and professional interactions. The parent noted that the YJS involvement was the most positive event for her child and their family.*

Child: *Practitioner, "if it wasn't for you I would not have gone back to school, I mean that. You have helped me more than I even thought you would, when nobody was listening and even my own family didn't believe what I was saying, you believed me. I'm in a different place now and I'm moving on with my life." (Prevention & Diversion Team Feedback).*

Victim: *"You're the first person to reach out to me since the incident happened 2 years ago, and I truly appreciate you checking in and updating me on the progress of the court case. You took the time to listen to me, which really meant a lot, and you made sure I knew what support was available. Without your contact I would have missed the chance to have my voice heard in Court and the opportunity to attend. Thank you for making sure I didn't go through this alone."*

Child: *"Victim awareness sessions went very well, she (RJ Worker) was easy to speak to and I was able to see myself like I have never done before, to be more open minded and reflective. I was able to put myself in the shoes of the victim, realise the impact of doing so and what could have gone wrong or even worse if the scenario was different."*

CHALLENGES

Challenge regarding the quality of the secure estate - An urgent notification was issued for Oak Hill on 31 July 2025, following a failed inspection. Oak Hill management and staff are currently developing an action plan to address the issues. Options for relocating children from Oak Hill are severely limited. Hackney's YJS has therefore increased contact with Hackney children who are either current or recent residents of Oak Hill. Of note, whilst Oak Hill has its issues, the "lived experience" of children there is generally not as poor as that of children in Feltham Young Offender Institution (YOI), where feedback on safety and staff access is universally negative, despite Feltham not being subject to an urgent notification.

Discussions are underway with ELFT about how to better engage CAMHS practitioners in Hackney's Prevent/ Channel processes. Furthermore, there remains a degree of uncertainty regarding the MPS reorganisation and the implications this will have on Youth Justice police officers & MASH.

HACKNEY HOUSING

EVIDENCE

In 2024-25, Hackney's housing strategy focused on creating genuinely affordable homes and improving housing services, though affordability remained a major challenge, with a housing strategy position statement approved in December 2024 and a new 5-year plan expected in late 2025. Key initiatives included building 1,000 new council homes and implementing schemes like Hackney Living Rent to offer homes below market rates. The borough also saw rising private rents and a growing housing register, with ongoing efforts to improve standards in the private rental sector and enhance safety compliance in council housing.

EVIDENCE

The Housing service continues to operate in a challenging borough context. As of June 2024, the average house price in Hackney was £590,000, which is 18.5 times the average household income of £31,580. Private rents increased to an average of £2,361 per month in July 2024. There are 8,500 households on the Council's housing register and 3,400 homeless households are in temporary accommodation. Approximately 4000 children were living in temporary accommodation. The Council has a significant challenge with the supply of social housing, with only 570 lets available between April 2022 and March 2023. Hackney is experiencing a significant increase in homelessness, with an 8% increase in temporary accommodation required year on year.

IMPROVEMENT

The Council has implemented a housing improvement plan to address issues around mould and dampness. The plan focuses on four key themes: response to regulation, workforce development, resident focus, and systems and data. A full stock condition survey is underway to identify issues and this information will be used to create an updated asset management strategy.

CHALLENGES

While Hackney has made notable progress in its 2024-25 housing strategy, significant challenges persist, particularly concerning affordability and supply. The Council's proactive measures, such as the commitment to deliver 1,000 new social rent homes and the implementation of a Housing Improvement Plan, demonstrate a clear focus on enhancing both the quantity and quality of housing. Moving forward, the forthcoming 5-year housing strategy in 2025 will be critical in consolidating these efforts and building upon the foundation laid by the 2024-25 position statement to create a more equitable and sustainable housing future for all Hackney residents.

THE METROPOLITAN POLICE SERVICE

EVIDENCE AND LEARNING

The MPS is no longer in ENGAGE phase as specific causes of concerns have been addressed. This is positive. In June 2023, the Mayor's Office for Policing and Crime in London commissioned HMICFRS to inspect how well the Metropolitan Police Service handled the sexual and criminal exploitation of children. HMICFRS carried out the inspection in September 2023 and issued three causes of concern and made 11 recommendations.

The causes of concern were as follows:

- **The force needs to improve how it identifies and assesses risks, and how it responds, when children are reported missing.**
- **The force should improve its investigations when children are at risk of, or harmed by, criminal or sexual exploitation.**
- **The force needs to make sure its officers and staff, at all ranks and grades, understand what victim blaming is and how it affects the service they provide.**

HMICFRS revisited the force between 30 September and 18 October 2024 to review its progress and found:

- **Senior leadership response to above issues had been positive and the cause for concerns were closed.**
- **The MPS children's strategy sets out the commissioner's ambition to adopt a child first approach.**
- **Through renewed focus on child exploitation, its links to missing children and the language officers and staff use has made positive progress.**
- **The changes (policy/guidance, training, uplift in officers) introduced by the MPS are also providing better outcomes for children in London.**

EVIDENCE

The Central East BCU received an uplift in officers during the reporting period to support Public Protection investigations. The officers arrived on BCU came with diverse range of policing experiences and added value. Our teams continue to provide business as usual in the areas of child safeguarding. Going forward the MPS like many partner organisations will face financial challenges and will need to make tough choices. Tough choices work is underway across the organisation.

IMPROVEMENT

Children reported missing:

- MPS has improved its policy and guidance and provided additional training including best way to improve its practice when children are reported missing.
- Saw an improvement in MPS's response when children are reported missing.
- MPS is better at planning for when children at risk of exploitation are reported missing and will strive to get better.
- MPS uses innovative methods to help find children.
- MPS has better oversight when children are reported missing.
- The MPS has improved how it shares information with its partners.

IMPROVEMENT

Child Exploitation:

- MPS is focusing more on safeguarding children.
- Tackling exploitation of children is a higher priority.
- More investigators have been trained in child exploitation.
- Number of officers working in exploitation teams has increased.
- More frontline officers and staff have been trained in child exploitation.
- Fewer delays in starting investigations.

IMPROVEMENT

Victim Blaming Language

- MPS has carried out substantial work to try and stop victim blaming language
- MPS encourages its officers and staff to challenge victim blaming language
- Most officers and staff recognise victim blaming language and understand its negative effect

EVIDENCE, LEARNING, IMPROVEMENT

On 26 September 2024, the MPS launched its new Children's Strategy to keep children in London safe, build their trust and bring to justice those who abuse and exploit children. This is a 5 year strategy. Around 2 million children live in London and the policing challenges they present are wide ranging from exploitation, to growing up among domestic abuse, to child abuse to a child carrying a knife. In 2023, there were approximately 61,000 child victims of crime and 51,000 children who were suspected of committing a crime.

Child first is an approach that has been developed using evidence of what works to reduce children engaging in criminal behaviour, achieving positive outcomes and create safer communities. Child first recognises that children are different to adults, they have different needs and vulnerabilities. Child first seeks to treat children as individuals and for professionals to understand the wider context of their lives. Child first ensures that work with children acknowledges their status as a child rather than treating them as adults.

What Child First Means for policing

- Those below 18 should be treated as children first.
- The vulnerability of children should be identified and responded to effectively in order to protect them from harm.
- Full understanding of children's circumstances should be sought.
- Every interaction is both an intervention and an opportunity. This is an opportunity to enhance relationships.
- The voice of children must be heard and their opinions respected.

EVIDENCE

While not formally evaluated, collaboration between Safer Neighbourhood Teams and schools has established 'safer corridors' and adjusted school detention times to protect children from becoming victims of crime on their way home.

IMPACT

CASE STUDY 1: *Six children obtained ABH level injuries whilst in a nursery and an employee was witnessed to have assaulted babies on two occasions. These concerns were shared with police via NHS colleagues post attendance at a hospital. An urgent referral resulted in joint working with LADO, OFSTED as well as statutory partners to plan investigation. This resulted in OFSTED suspending the licence to provide nursery provision. Communication took place with parents which resulted in multiple parents coming forward with concerns. Joint working and cooperation with parents and a child centred investigation resulted in the obtaining of witness testimonies. Post evidence being secured, police focused on enforcement, resulting in the arrest and interview of two persons who have now been charged with multiple offences (cruelty and neglect). A trial date is set for 2027.*

CHALLENGES

The MPS faces a £260 million budget deficit. This is a significant challenge for our organisation. To reduce the funding gap, work has been completed to make savings. Despite this the MPS needs to make 'tough choices'. This in essence means that our workforce size will shrink to match our budget. In total, the size of our workforce will be reducing by c1700 and majority of this will be officer numbers. Finer detail is being worked on and we will know the detail and impact in due course.

NHS NORTH EAST LONDON INTEGRATED CARE BOARD

EVIDENCE, LEARNING AND IMPACT

Hackney Trauma Informed Multi-Agency Practice: Responding to Child Victims of Domestic Abuse: A Partnership Steering Group was established to review and identify good practice already happening within services across the partnership, and to develop a whole-system trauma informed response across universal and targeted services to child victims of domestic abuse. A Guidance Doc for Trauma Informed Support for Children and Young People was developed which provides organisations and professionals with approaches and resources relevant to their agencies to advise and support child victims of domestic abuse.

Sudden Unexpected Death in Infancy (SUDI): Work has continued following the SUDI Conference in March 2024 utilising a NEL wide approach to review and focus on SUDI reduction. This work is ongoing and involves a number of key partners and CDOP colleagues to engage in quality improvement work with identification of key data interrogation.

The Tree of Life: For the past three years, the Tree of Life in Schools Programme in City and Hackney has been providing African, Caribbean, and mixed heritage young people with a unique form of culturally attuned mental health support.in collaborative partnership between local schools, NHS Mental Health Support Teams, and voluntary sector organisations. Partners included Child and Adolescent Mental Health Services (CAMHS) East London NHS Foundation Trust, Hackney CVS, NHS North East London ICB, Wellbeing and Mental Health in Schools Service (WAMHS), Hackney Council and the City of London Corporation.

City and Hackney Childhood Adversity, Trauma and Resilience Programme (ChATR): ACEs and Trauma-informed Practice Training is now available on the City and Hackney Children Safeguarding Partnership (CHSCP) Training Platform. In collaboration with the Trauma Services Lead at Tavistock & Portman FT, a Train the Trainer model for training of facilitators was developed to deliver the ChATR ACEs & TIP Training. The ChATR Online Resource Portal has been relaunched to align it with the ACEs and TIP Training. The ChATR portal includes a range of practice tools, academic research and video resources.

The Named GP in City and Hackney: Has effectively supported and represented GPs at partnership and strategic events. This has included GP participation in multi-agency audits, rapid reviews, safeguarding partnership meetings and the Child Death Overview Process (CDOP). This allows a GP voice to scrutinise local child deaths and identify system gaps for improvement in general practice. Over 150 GPs, practice nurses, and physician assistants have received level 3 safeguarding training, with over 80% of attendees rating the content as very useful and relevant. Participants praised the engaging presentations, with real-life scenarios and Mentimeter interactivity. Additionally, reflective safeguarding sessions have been well attended by GP safeguarding leads, providing opportunities increased training and opening channels for feedback directly into the partnership from GP's.

HOMERTON HEALTHCARE NHS FOUNDATION TRUST

CHALLENGES

The **national reconfiguration** of ICBs will mean challenge in meeting the required 50% reduction in operating costs. Whilst the statutory requirements for safeguarding will need to be met it is currently unclear what this will look like locally.

Identification and Referral to Improve Safety (IRIS) - Public health have withdrawn 50k of funding as part of cost saving and the service cannot continue on a reduced financial envelope. NHS NEL ICB have provided extra financial funding to continue the service for another year. Alternative funding / options being explored. IRIS has been running in C&H since 2007.

EVIDENCE

Overall, there has been no reduction in the growth of the contemporary safeguarding children's agenda which the Homerton has had to respond to. Nevertheless, staff have access to expert safeguarding advice, support, training, and supervision. The Homerton SCT and related staff have continued to contribute to the development and ongoing scrutiny of the multiagency safeguarding arrangements primarily through the work of the CHSCP. Homerton ED continues to see growth in the cohort of vulnerable children with disabilities and additional needs who present in mental health and behavior crisis some require in patient care. This reinforces the need for a paediatric Learning Disability Nurse who can support this vulnerable group of children as well to enable staff to work effectively with these children and their families. There have been ongoing discussions with the commissioners regarding this issue. Recruiting to specialist children posts such as health visiting, paediatric nursing is a challenge locally and nationally.

Overall, whilst innovation and good practice is ongoing, the workforce challenges in specialist children roles persist, there are internal pressures to meet saving targets, continued increases in the safeguarding agenda at a national level (which include the implementation of the Families First Partnership Programme), the unknown must do's from the Children's Wellbeing and Schools Bill, coupled with the changes in NHSE which will impact on the statutory safeguarding responsibilities of ICBs. This means that there are challenging times ahead for provider healthcare organisations.

EVIDENCE AND IMPACT

Enhanced Health Visiting Service (EHVS) is key in the early identification of safeguarding risk and need, particularly among families who may not otherwise be visible to services. As a non-stigmatising, universal service, health visitors uniquely engage with all families with children under five, regardless of explicit health needs. This universal access enables early intervention and the provision of targeted, intensive support to vulnerable families.

EVIDENCE AND IMPACT

CAMHS - An Executive group for WAMHS has been created with the Head of Community CAMHS and Specialist CAMHS, Directors of Education and SEND. To look across Hackney school at strategic joint pathways, role of CAMHS in to safeguard children from increased exclusion and to scrutinise practice and learnings from exclusions to change practice. Recent changes to autism and co-occurring ADHD for new referrals using the hub and spoke model, meaning access to diagnosis whilst in treatment, cutting out secondary long wait hopefully eliminating further referrals and distress.
This has come about following a QI and pilot project collecting feedback for parent and CYP on the effects of the new model. All resoundingly positive benefits for clinicians too, in terms of ethical practice.

EVIDENCE AND IMPACT

Children Therapy Services - As one of the outcomes from Child V child safeguarding practice review therapists and the Named Professionals are developing resources to identify neglect and the evidence base for non-engagement with health appointments in non-verbal CYP with profound physical disability. Children's OT have made considerable progress in developing and embedding integrated pathways that enhance patient safety and reduce risks for vulnerable children. These have focused on four key areas:

- **Fire Safety Risk Assessment:** A holistic approach has been implemented to balance fire safety legislation with a child's abilities and the risk of absconding, creating safer environments compared to other boroughs that rely heavily on 1:1 care packages through co-production of an updated fire safety risk assessment.
- **Safer Spaces Pathway:** Designed for children with self-harming or challenging behaviours, this pathway ensures MDT collaboration and considers developmental needs, deprivation of liberty, and psychological factors.
- **Reducing Delays in Assessments:** New systems were established to track, assess, and expedite high-risk cases, ensuring timely interventions. A 'fast-track' pathway was co-developed with the LBH Adaptations Team to address urgent cases efficiently.
- **Integrated Problem-Solving:** Monthly risk management meetings have been introduced to ensure collaborative decision-making across health, social care, and housing teams, providing coordinated solutions for complex cases.

These integrated pathways have significantly improved patient safety, with key outcomes such as reduced waiting times for assessments—decreasing from an average of 5.5 weeks to 3 weeks despite an increase in referrals. Additionally, formal complaints have been eliminated in the current period, compared to three in the previous year, further demonstrating the effectiveness of the service.

EVIDENCE

Midwifery - Maternity safeguarding is launching the HOPE Box project. In summer 2025. This work brings together midwifery, social care, health visiting and charity organisations including Birth Companions for an MDT approach in supporting women and families at risk of separation from their babies.

IMPACT

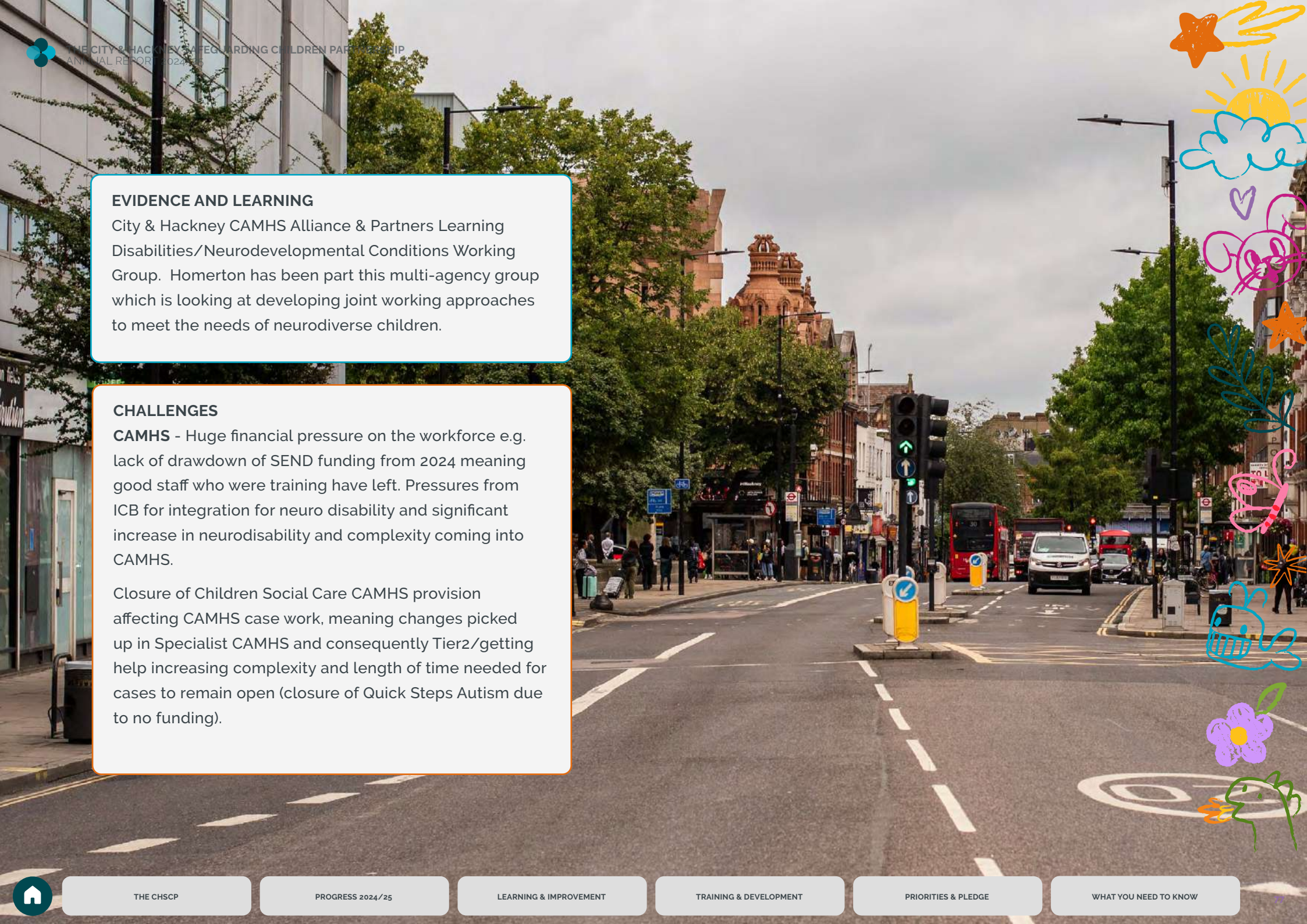
School Based Health Service - The SBHS continues to offer assessments to all children entering child protection plans, with over 90% of CYP seen. The service has updated the contract variation to clarify responsibilities for children in local authority settings and City and Hackney residents.

EVIDENCE AND IMPACT

Talking Therapies - City and Hackney Talking Therapies is a primary care mental health service delivering short term, mostly Cognitive Behavioural Therapy oriented therapy, to adults with common mental health problems. The service has worked closely relationship with City and Hackney community CAMHS to provide a small bespoke treatment pathway for over 16-year-old patients who CAMHS determine to be suitable for therapeutic interventions. Within the last year an additional treatment pathway that prioritises the assessment and treatment of parents who have a child who is being seen within a CAMHS service. Although cases are small in number, this pathway supports the family unit receiving mental health intervention as they manage their challenging circumstances.

In addition, an internal child safeguarding support role was created which offers specific support to all our clinicians regarding the development of greater confidence in assessing and managing child safeguarding concerns. Such concerns may arise in any communication with a patient, and this role seeks to support staff in sensitively having such conversations with patients and holding more accurate knowledge around the role and function of child social care services. Additionally, from time to time our clinicians are requested to attend various child protection meetings and having this extra specialist support will also advise on the expectations and engagement in such.

This role has not been created to replace the function of the SCT who continue to advise our staff on child safeguarding concerns and recommended actions. This new role is primarily intended to provide our staff with skills and knowledge to feel more confident in child safeguarding assessment, and in having accurate child social care information to support such patient conversations.



EVIDENCE AND LEARNING

City & Hackney CAMHS Alliance & Partners Learning Disabilities/Neurodevelopmental Conditions Working Group. Homerton has been part this multi-agency group which is looking at developing joint working approaches to meet the needs of neurodiverse children.

CHALLENGES

CAMHS - Huge financial pressure on the workforce e.g. lack of drawdown of SEND funding from 2024 meaning good staff who were training have left. Pressures from ICB for integration for neuro disability and significant increase in neurodisability and complexity coming into CAMHS.

Closure of Children Social Care CAMHS provision affecting CAMHS case work, meaning changes picked up in Specialist CAMHS and consequently Tier2/getting help increasing complexity and length of time needed for cases to remain open (closure of Quick Steps Autism due to no funding).

EAST LONDON NHS FOUNDATION TRUST

EVIDENCE

ELFT maintains a robust safeguarding governance framework, ensuring effective leadership, accountability, and multi-agency collaboration across all services and boroughs. Safeguarding is a core responsibility embedded at all organisational levels, reflecting the Trust's values. The Trust contributes strategically and operationally through participation in various safeguarding partnership boards, subgroups, and local assurance meetings. This includes engagement in local audits, multi-agency training, and strategic reviews such as Safeguarding Adult Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs), Domestic Abuse Related Death Reviews (DARDR), Channel Panels, and PREVENT/CONTEST Boards. The Trust Safeguarding Committee meets quarterly to provide challenge and assurance regarding safeguarding arrangements and monitors compliance. Quarterly reports are submitted, providing assurance against responsibilities outlined in CQC Regulation 13, Contractual Safeguarding requirements, the Children Act (1989/2004), and the Care Act 2014.

EVIDENCE AND IMPROVEMENT

The Trust has implemented an improved reporting process for CSC referrals. From 1 April 2025, all staff are mandated to complete an InPhase incident report form concurrently with any child protection referral to CSC. This measure will enable timely and accurate data capture, effective oversight by the safeguarding team and prompt, effective intervention.

EVIDENCE AND LEARNING

The Trust has demonstrated strong improvement in safeguarding training compliance across both children and adult safeguarding in 2024/25. Level 3 Safeguarding Children training compliance rose to 89%, up from 83% in 2023/24 – a 6.7% increase year-on-year.

EVIDENCE AND IMPACT

Mental Health Support Team and Wellbeing and Mental Health in Schools: The launch of the Low-Level Concerns guidance was supported through two CAMHS in Schools Forums, where staff explored its application and received input from safeguarding leads across the partnership. We collaborated with Educational Psychology, Public Health, and Hackney Education on responses to school-based trauma, such as sudden deaths and community incidents. We also continue to support suicide prevention through staff training and policy development in schools.

Child A was referred to social care after risk of grooming and county lines emerged. The clinician supported the parent, ensured police involvement, and maintained confidentiality safeguards at school. The child is no longer considered at risk.

Child B came from a previously unknown family of five. The clinician identified safeguarding concerns, made trauma-informed referrals to Early Help and the Children's Centre, enabling broader family support.

Child C, showing extreme aggression, was supported through coordinated agency input (including YOT and social care). A full risk and mental health formulation was documented, supporting a timely response.

Emotional & Behavioural Team (E&B): The E&B team maintains regular safeguarding supervision and utilises MASH and trust safeguarding consultations to inform safe and timely care planning. Weekly MDTs support risk-based decision-making, and a new consultation pilot is helping clarify CAMHS involvement while families await assessment. The team works closely with schools and Local Authority services, referring complex joint CAMHS/CSC cases to the Complex Case Forum and ensuring smooth service transitions.

Case 1: A family with domestic abuse, parental mental health issues, and neurodiverse needs was supported collaboratively by CAMHS and Family Support, with effective TAC coordination leading to improved engagement.

Case 2: After Early Help initially closed a case, a joint MASH referral by CAMHS and school led to reallocation to a senior Early Help social worker. A robust package of support was arranged, and the father expressed gratitude for the collaborative care.

Continued overleaf.

EVIDENCE AND IMPACT CONTINUED

Behaviour Support and Outreach (BS&O): **BS&O's proactive, no-waitlist** model enables swift risk response and family stabilisation. Strong links with MACE, EFRP, MASH, and local authority partners support contextual safeguarding work.

A referral for ADHD assessment led to a broader safeguarding concern being uncovered. MDT discussion led to MASH referral due to serious neglect and physical harm between siblings. All three children were placed on Child Protection Plans. Despite parental criticism over the non-diagnosis of ADHD, the case exemplified strong safeguarding vigilance and thorough clinical assessment

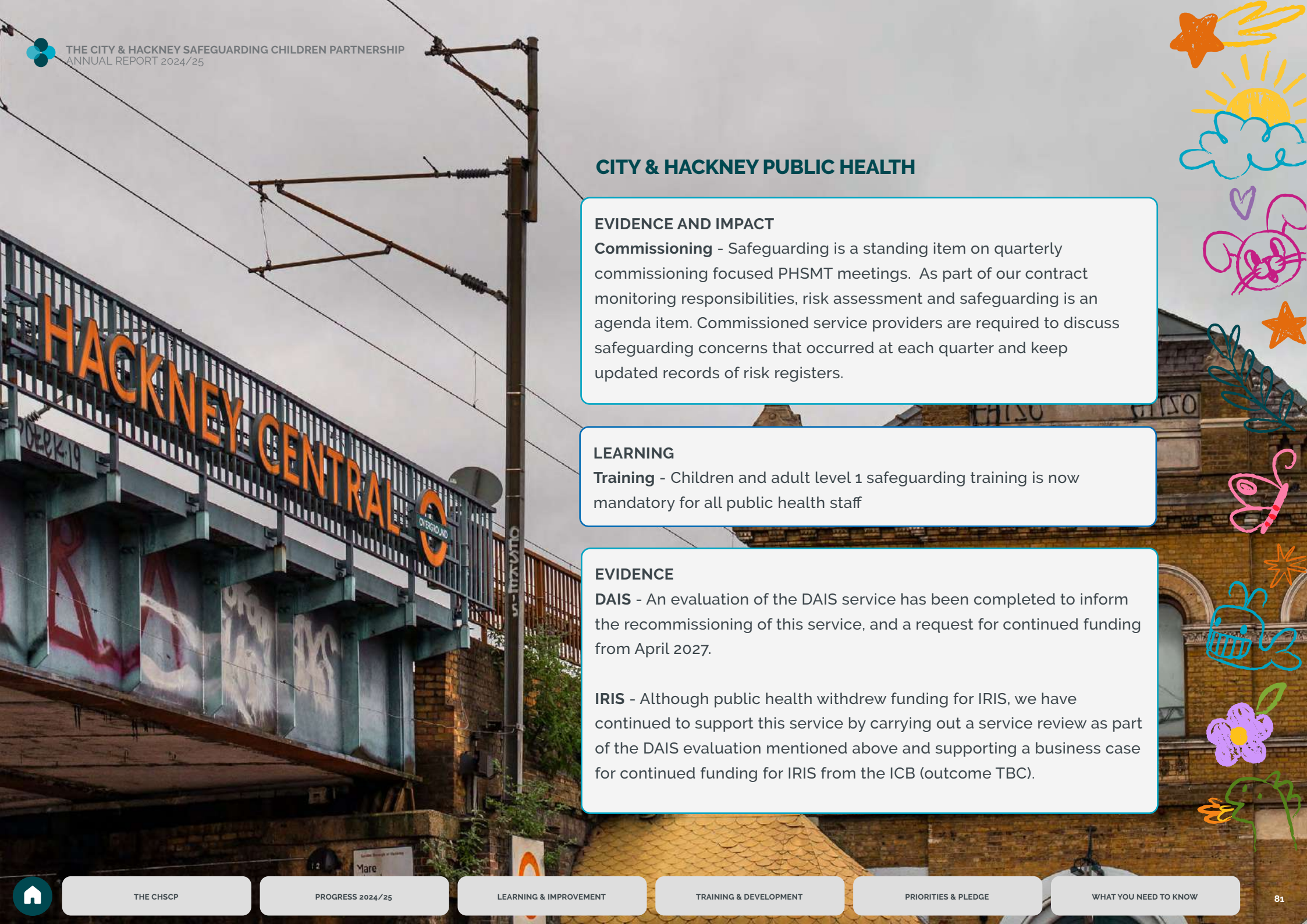
Adolescent Mental Health Team (AMHT): AMHT engages in early consultation with MASH and works jointly with social care, Early Help, education, and other agencies. Clinicians attend multi-agency meetings and reflect on complex cases in MDTs. Joint visits and care planning are common, with attention paid to addressing environmental factors affecting young people's mental health.

Neurodevelopmental Team (NDT): NDT contributes to multi-agency risk and planning forums such as the Dynamic Support Register (DSR) and LDA subgroup, focusing on young people with Learning Disabilities and Autism. Safeguarding consultations are regularly sought, and all cases with risk of admission are reviewed via LAEP meetings to prevent unnecessary inpatient stays. The team also contributes to service improvement work around Fetal Alcohol Spectrum Disorder (FASD), and has responded to a recent Serious Incident with enhanced risk recording and TAC documentation processes.

CHALLENGES

This year, our safeguarding work has reflected a deep commitment to integrated, trauma-informed, and child-centred care, despite the mounting pressures across health, education, and social care. We have responded to complex and evolving risks, strengthened frontline practice, and maintained a focus on vulnerable groups, including those affected by contextual harm, neurodevelopmental needs, and digital exploitation.

Looking ahead, our priorities will include improving the quality and consistency of multi-agency collaboration, especially in the absence of some previously established forums; enhancing digital safeguarding approaches in response to emerging online risks; and supporting workforce capacity in light of system-wide financial pressures. In alignment with City & Hackney's wider priorities, particularly around early intervention, equity of access, and coordinated care, we will continue to drive safe, responsive, and relational safeguarding practice across CAMHS.



CITY & HACKNEY PUBLIC HEALTH

EVIDENCE AND IMPACT

Commissioning - Safeguarding is a standing item on quarterly commissioning focused PHSMT meetings. As part of our contract monitoring responsibilities, risk assessment and safeguarding is an agenda item. Commissioned service providers are required to discuss safeguarding concerns that occurred at each quarter and keep updated records of risk registers.

LEARNING

Training - Children and adult level 1 safeguarding training is now mandatory for all public health staff

EVIDENCE

DAIS - An evaluation of the DAIS service has been completed to inform the recommissioning of this service, and a request for continued funding from April 2027.

IRIS - Although public health withdrew funding for IRIS, we have continued to support this service by carrying out a service review as part of the DAIS evaluation mentioned above and supporting a business case for continued funding for IRIS from the ICB (outcome TBC).

EVIDENCE AND IMPACT

System leadership - Public health led the completion of a review of the health and social needs, and inequalities, faced by Families in Temporary Accommodation. This review includes an overview of the evidence base, local insights and local support / provision and will inform system work to support the needs of this vulnerable cohort.

EVIDENCE, IMPACT AND LEARNING

Identified from service that Public Health commissions:

Health Visitors supporting caseloads of the most vulnerable families receive additional supervision from a Parent-Infant Psychotherapist and an Integrative Child Psychotherapist monthly in the form of reflective practice, to ensure that they receive the appropriate support required to safely and effectively manage complex cases.

The **Schools Based Health Service** conducted an audit of safeguarding assessments, ensuring adherence to quality and compliance standards. The audit revealed a high level of compliance with child-centred practices; however, it also identified areas for improvement, such as inconsistent documentation following handovers and variability in the care packages provided. The audit served as an opportunity to address these gaps promptly, leading to the implementation of digital monitoring for safeguarding sessions and regular reviews of documentation during both school nursing team meetings and supervision sessions.

CHALLENGES

Meeting the needs of socially vulnerable pregnant women and new mothers is a key priority. We are focused on strengthening our services to ensure they receive the support they need. The Community Peer Mentoring Service, which began in November 2022, has not fully delivered on its intended outcomes and so the service will come to an end earlier than planned, in December 2025. We are also working with the Enhanced Health Visiting Service, commissioned in September 2023 to evaluate the impact of this service on this vulnerable cohort and are actively collaborating with the provider to improve the performance of these services.

CAFCASS

EVIDENCE

Between April 2024 and March 2025 Cafcass received a total of 16,195 children's public law cases.

Between April 2024 and March 2025 Cafcass received a total of 11,430 care applications. This figure is 0.4% lower than the previous financial year.

The average for 2024-25 was 41 calendar weeks, which is 3 weeks lower than the previous year.

Between April 2024 and March 2025 Cafcass received a total of 39,182 children's private law cases. This figure is 0.7% lower than the previous financial year.

PROBATION

EVIDENCE, IMPACT AND LEARNING

Over the past year, we have placed significant emphasis on learning and development, with updated training courses delivered on safeguarding children and adults, as well as domestic violence. These efforts have strengthened staff awareness and confidence in managing complex safeguarding concerns.

In addition, we have established stronger connections with specialist services within the borough, helping to clarify the support available and enhance our child-centred approach to risk management. This collaborative work ensures that interventions are informed, responsive, and aligned with best practice. We have also driven forward improvements in the quality of assessments. This has been achieved through case dip-sampling, which ensures safeguarding concerns are being addressed in line with our statutory duties.

A continued focus has been placed on the accurate recording of safeguarding checks and responses across the PDU. This enables us to evidence the work being undertaken, particularly in relation to child safeguarding, and supports a culture of accountability and continuous improvement.

IMPACT

CASE STUDY 1: *The removal of a Registered Sexual Offender (RSO) from a residence where unsupervised contact with children was taking place led to a disclosure of offending behaviour. This decisive action eliminated the immediate risk posed to children and ensured the RSO was relocated to suitable accommodation, aligned with safeguarding protocols. This case exemplifies the importance of proactive risk management, multi-agency collaboration, and the effective use of assessment tools in protecting vulnerable individuals and upholding public safety.*

IMPACT

CASE STUDY 2: *During a routine home visit, professionals observed damage to the door of the property, which prompted further professional curiosity. This observation was escalated to the allocated social worker, enabling additional assessments to be carried out. As a result, risk mitigation strategies were implemented to ensure the overall safety and wellbeing of the child. This case highlights the importance of frontline staff remaining vigilant and responsive to environmental cues, and how such actions can lead to timely safeguarding interventions.*

CHALLENGES

Staffing and Capacity: Recruitment remains a key focus, with a plan in place and ongoing efforts to increase staffing levels. While numbers are improving, we are not yet at full complement and continue to experience capacity pressures, which are being monitored and actively managed.

New entrants require comprehensive training and time to build experience, particularly given the complexity of cases across the caseload. Senior Probation Officers (SPOs) are allocating cases based on skills and experience, while also providing mentoring from experienced staff, themed case discussions and workshops and enhanced oversight for complex cases.

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. In line with paragraph 2.1 of the London Safeguarding Children Procedures, 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.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.
- Behaved in a manner that discriminates against a child on the basis of one or more of their protected characteristics as defined by the Equalities Act 2010.

Further criteria (paragraph 2.2.) relates to allegations that can be made in relation to physical chastisement and restraint but can also relate to inappropriate relationships between members of staff and children or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see s16-19 Sexual Offences Act 2003).
- 'Grooming', i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 Sexual Offences Act 2003).
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature e.g. inappropriate text/e-mail messages or images, gifts, socialising etc.
- Possession of indecent photographs/pseudo-photographs of children.

Paragraph 2.3 of the procedures define were these should be applied when there is an allegation that any person who works with children:

- Has behaved in a way in their personal life that raises safeguarding concerns. These concerns do not have to directly relate to a child but could, for example, include arrest for possession of a weapon.
- As a parent or carer, has become subject to child protection procedures.
- Is closely associated with someone in their personal lives (e.g. partner, member of the family or other household member) who may present a risk of harm to child/ren for whom the member of staff is responsible in their employment/volunteering.

Once contact has been made with the LADO service, it will result in one of the five following actions being taken:

- The contact/referral is managed by a LADO in another local authority.
- A consultation takes place where the matter is discussed between the referrer and the LADO to decide on what action to take next.
- An evaluation meeting is held when the contact provides information that would suggest there is potential risk in the person's employment but would require further information before the decision is made that LADO oversight or an investigation is required.
- Guidance and oversight are offered by the LADO when an employer is completing an internal investigation.
- An Allegations against Staff and Volunteers (ASV) meeting will be convened when it has been decided by the LADO that the threshold of harm/risk has been met.

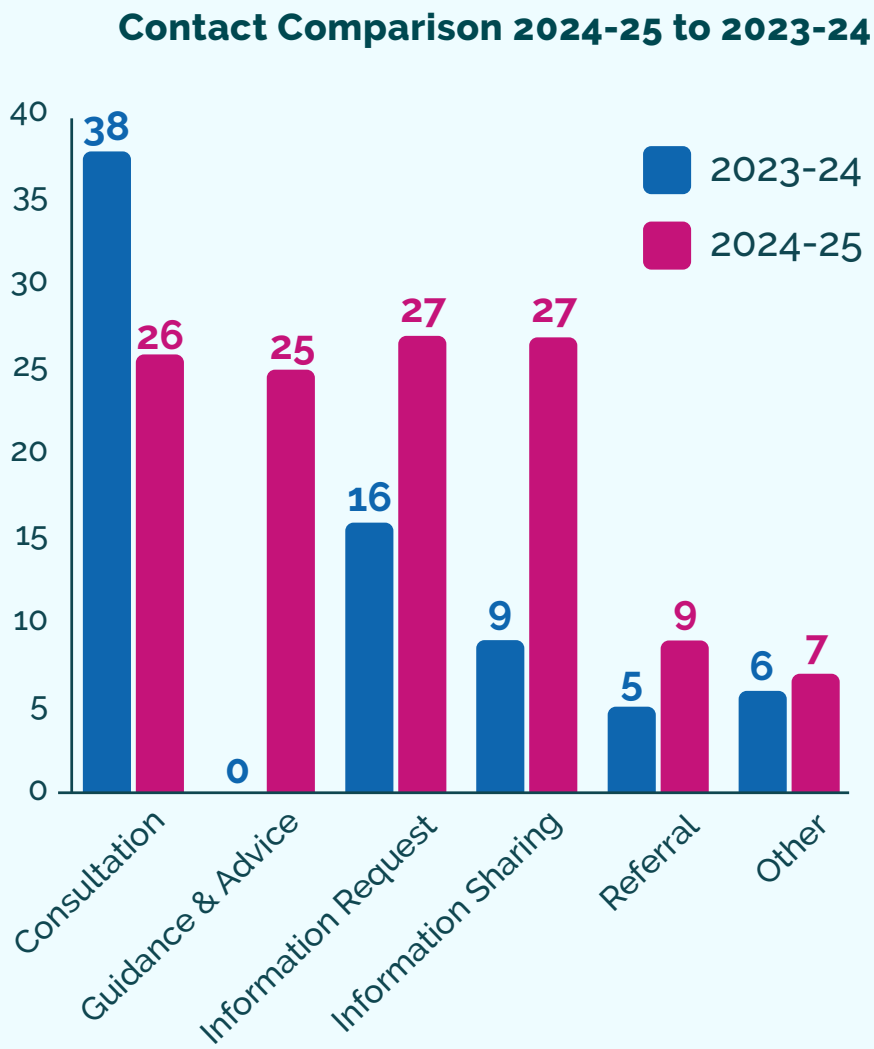
The City of London

EVIDENCE

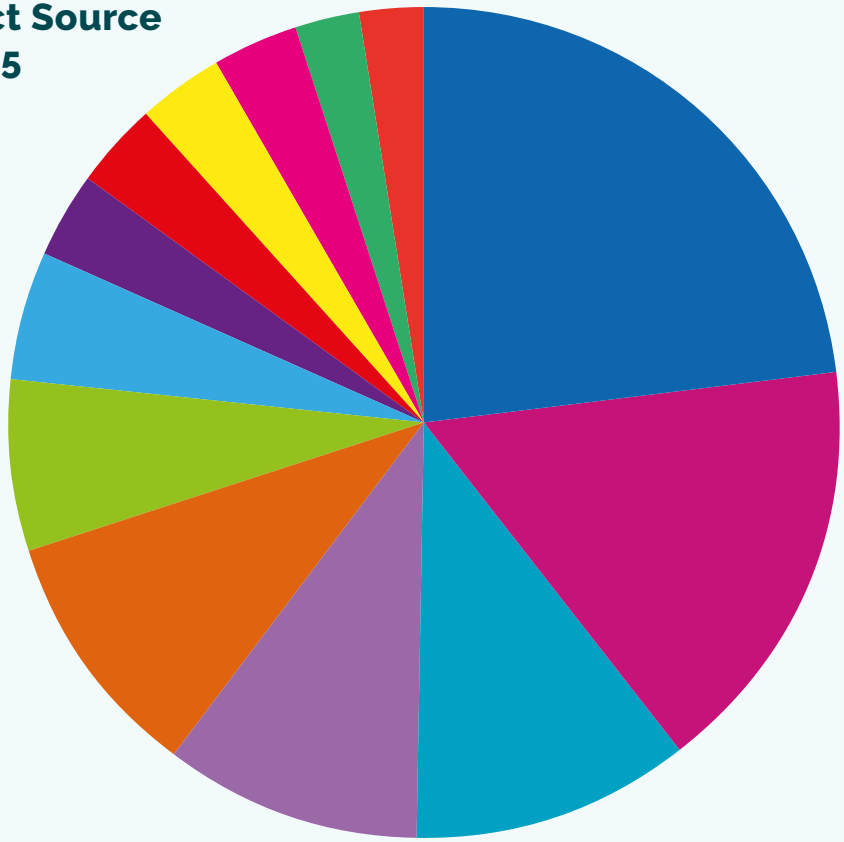
'There are effective arrangements in place to oversee and manage allegations against professionals. Work is completed in a timely way. The local authority designated officer (LADO) provides effective guidance, support and training to external agencies.' **City of London Ofsted, 2024**

EVIDENCE

This year there have been 122 contacts to the LADO Service, this is an increase of 48 from the previous reporting year, which is a 65% increase of contacts to the service. The increase in contacts is in line with London and National trends as is the fact that the vast majority of these, do not meet the LADO threshold. The increase in numbers is also attributable to improved recording methods. There has also been a change to the categories of contacts recorded to include guidance and advice. Contacts recorded as consultations generally require a one-off conversation to ensure that all aspects of the situation have been considered, and that appropriate action is taken to reduce any risk and improve conduct. Those instances where guidance and advice is provided often results in further action by the employer, such as an internal investigation with oversight from the LADO, rather than requiring an Allegation against Staff and Volunteers Meeting which would be recorded as a referral.



Contact Source 2024-25



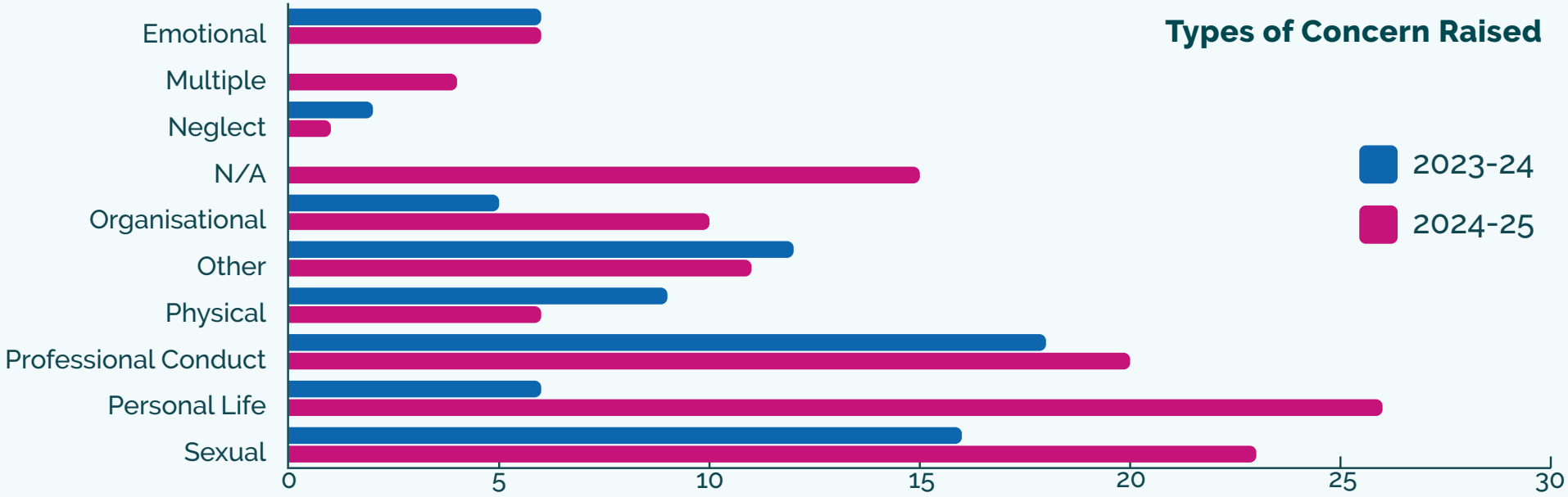
- Other LA/LADO (28)
- Other (20)
- Education Primary (13)
- CVS (12)
- Education Secondary (12)
- Police (8)
- Inspectorate (6)
- Adoption Agency (4)
- CoL Corporation (4)
- Health (4)
- Religious Agency (4)
- CoL Police (3)
- Early Years (3)

EVIDENCE

There continues to be a wide range of agencies contacting the LADO, which demonstrates that the process is known and understood across a broad range of partners. The sectors with the highest level of contacts are 'Other LA/LADO' (23%) which is likely to relate to and the cross over with multiple Local Authorities in terms of where jurisdiction and responsibility may fall. The Head Offices of several agencies are also located in the City, so whilst professionals may not physically work in the City, their agency 'employer' is based here. Such cases are responded to in a timely and effective manner by the LADO, to ensure risk is managed by the appropriate area. The ongoing good level of contact between the City of London Police and LADO (as well as other area Police forces) remains positive.

EVIDENCE

In relation to the types of concerns being reported to the LADO Service, the four categories of harm (as per child protection procedures) are used alongside types of concerns relating to an individual's personal life that could present transferable risk factors to their employment or work with children. The categories are recorded in line with the presenting issue identified during the initial contact with the LADO.



	Emotional	Multiple	Neglect	N/A	Organisational	Other	Physical	Professional Conduct	Personal Life	Sexual
2023-24	6	0	2	0	5	12	9	18	6	16
2024-25	6	4	1	15	10	11	6	20	26	23

EVIDENCE

There continues to be a high level of reporting in relation to concerns of a sexual nature. This is positive and continues to demonstrate the impact of several high-profile sexual abuse prosecutions and 'Me Too' movement. This is a mix on non-recent and recent incidences and online offences.

EVIDENCE AND IMPACT

Of the 10 contacts that met LADO threshold and were classified as referrals, two remained open at the end of the reporting year as further information was being sought from Police and the employer. Three were transferred to other Local Authorities as this is where the employer was based. Three referrals triggered Allegations against Staff and Volunteers (ASV) Meetings. Two of these resulted in a substantiated outcome and one in an unsubstantiated outcome.

A substantiated outcome means *"there is sufficient evidence to prove the allegation that a child has been harmed or there is a risk of harm"* whilst unsubstantiated means *"there is insufficient evidence to either prove or disprove the allegation. The term, therefore, does not imply guilt or innocence".* Two involved sexual concerns whilst the third was physical. Where there was a substantiated outcome actions were made to refer to DBS, which is a legal duty for employers. In one case the statutory body was notified and there were ongoing internal HR processes initiated. In all cases individuals have been removed from their work with children in a timely way.

LEARNING

LADO training continues to be provided through the CHSCP facilitated jointly by the Hackney LADO and the City LADO. It also continues to be well attended with positive feedback. Bespoke training requests for specific settings or teams can be provided as needed. The LADO also attends and contributes to the Safeguarding in Education Forum on a quarterly basis. The overview of the LADO continues to be part of bi-annual People's Directorate Inductions which last took place on 15/11/2024. A LADO podcast has also been recorded for Early Years workers who often struggle to attend day time training sessions, this can be found on the Family Information Service website; Training, forums and continued professional development - City of London Family Information Service.

EVIDENCE

This year there has been continued focus on developing support tools to aid consistency and clarity in relation to LADO and employment processes. A LADO Referral Form has been developed and now sits on the CHSCP website as well as a guide for parents/carers who are considering engaging a private tutor or similar. An overview LADO leaflet has been updated and distributed. Also in train is the development of some guidance for employers around making referrals to the DBS, this is being produced in conjunction with the DBS Regional Outreach Advisor for London.

IMPROVEMENT

Priorities for the next 12 months include continuing to refine and develop the LADO training offer, to update website information and to refine recording systems to ensure that data and performance can be easily analysed and extrapolated. Significantly, concerted efforts to be made to reach out to religious institutions in the City to raise awareness of the LADO arrangements and offer of training.

Hackney

EVIDENCE AND IMPACT

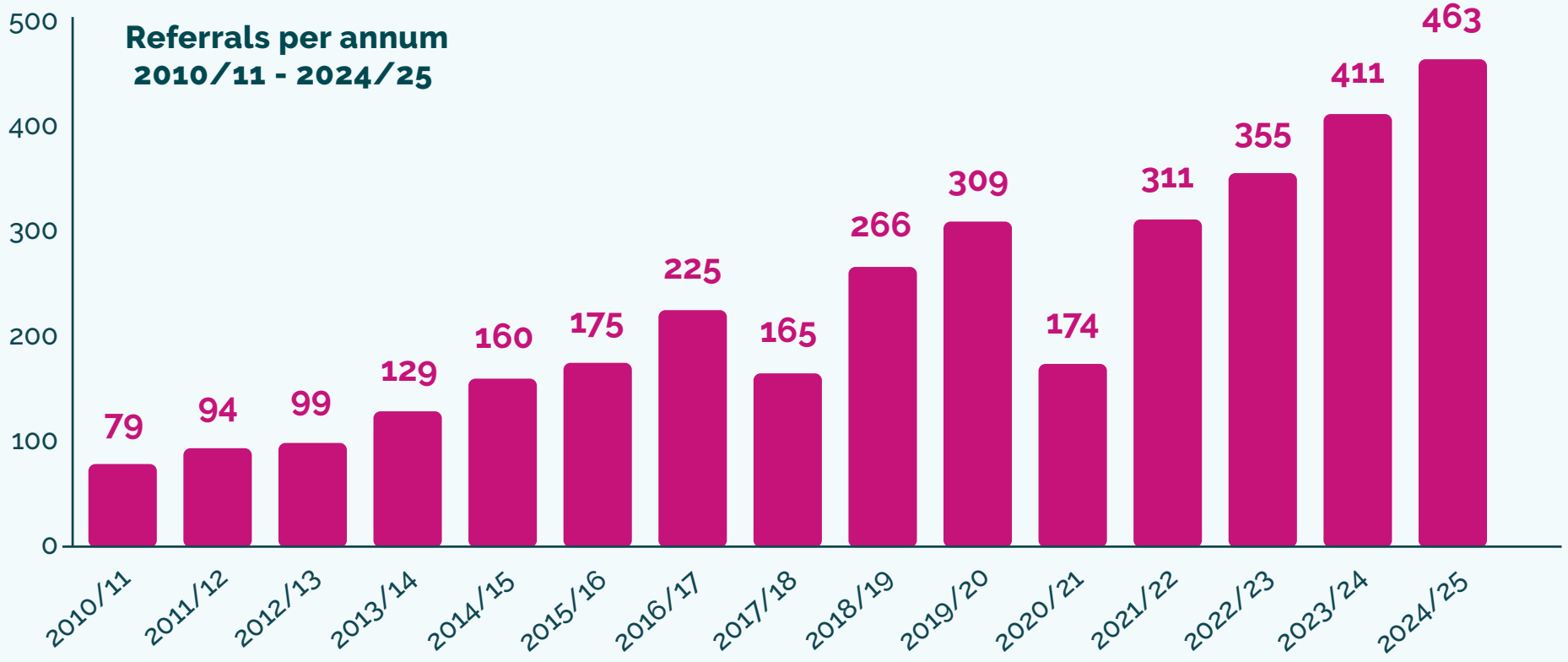
An effective local authority designated officer (LADO) service operates with clear systems in place to ensure timely responses to allegations against professionals. Partnership working is strong, and managers are ably assisted by the LADO to carry out their responsibilities. Training is relevant and routinely provided to partners to increase surety of their safeguarding practice' **Hackney Ofsted, 2024**

EVIDENCE, IMPACT AND LEARNING

A Peer Review was completed 31 May 2024 by the Islington LADO Service. It covered a strategic overview, operational functions, data collection and case file standards. As part of this process, a self-audit was also undertaken. Findings included: *The Hackney LADO service provides an efficient service in delivering management oversight of allegations against staff and volunteers who work with children. Thresholds are applied fairly and proportionally with clear management rationale. The range of referral sources suggests that the training delivered across the partnership has been successful in embedding the LADO role and ensuring employers understand their statutory duty in this area of work. The partnership has provided overwhelmingly positive feedback in this peer review in terms of scrutiny, decision making and containing the anxiety this area of work can raise. The safety of the workforce and the children they serve is clearly at the core of the service. Recording of contacts to LADO and the outcomes are clear. Further discussion around recording on Mosaic will be important to ensure potential patterns of behaviour of staff are picked up. Succession planning and management oversight will be important to ensure this high-quality service continues in [the LADOs] absence. The Hackney LADO is seen as an exponent of good practice across the London LADO network and a supportive member of the team.*

EVIDENCE

The LADO service received 463 contacts during the period of 1st April 2024 to 31st March 2025 which is an increase of 52 (12%) on the previous year (411 contacts). Other than during the COVID-19 pandemic, the trajectory of year-on-year increases in LADO contacts continues.

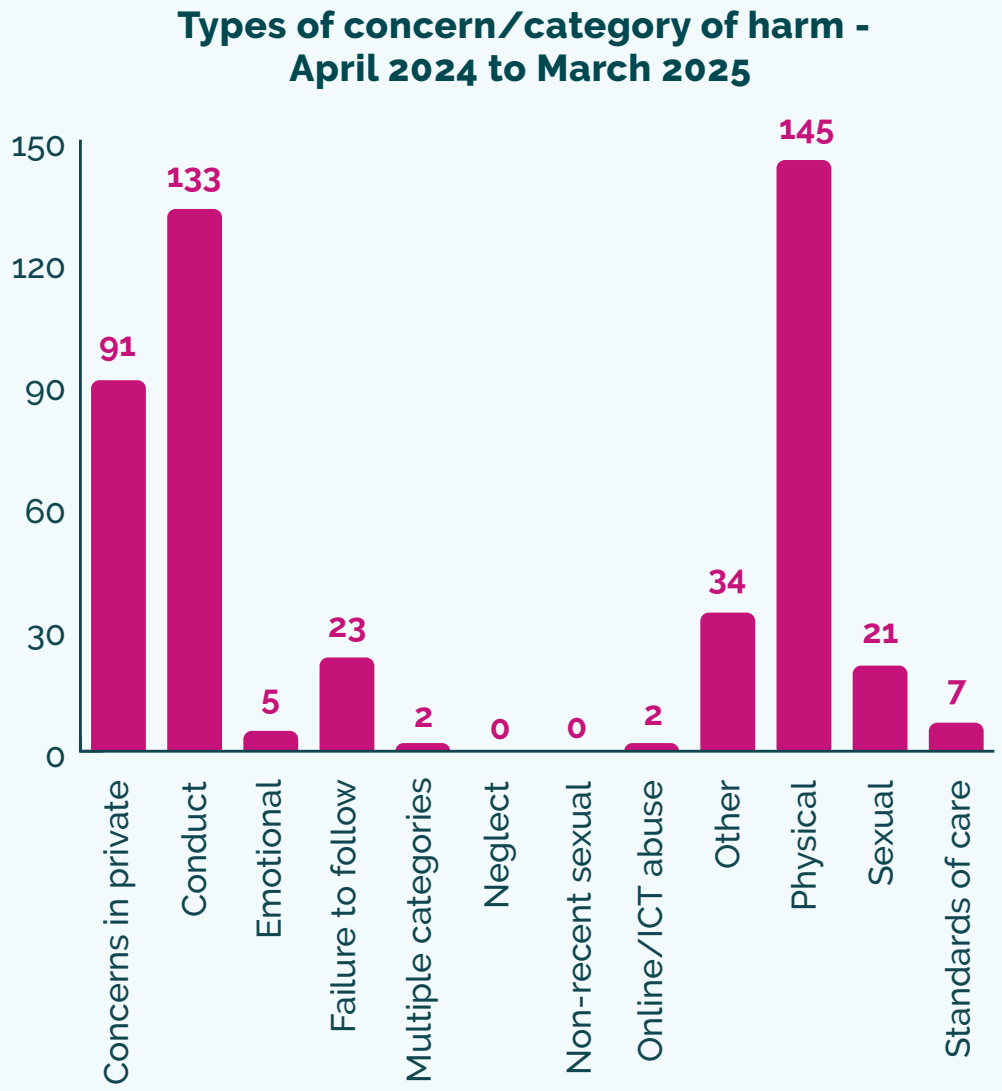


EVIDENCE

The occupations with the highest number of contacts were school support staff (23.6%), teachers (22.4%) and nursery workers (14.4%) which remains consistent with 2022/23 figures of 26.5%, 25.6% and 11.8% respectively. This is likely attributable to the higher ratio of children to staff given schools and day care provisions have higher numbers of children accessing services compared with health or leisure facilities for example.

EVIDENCE

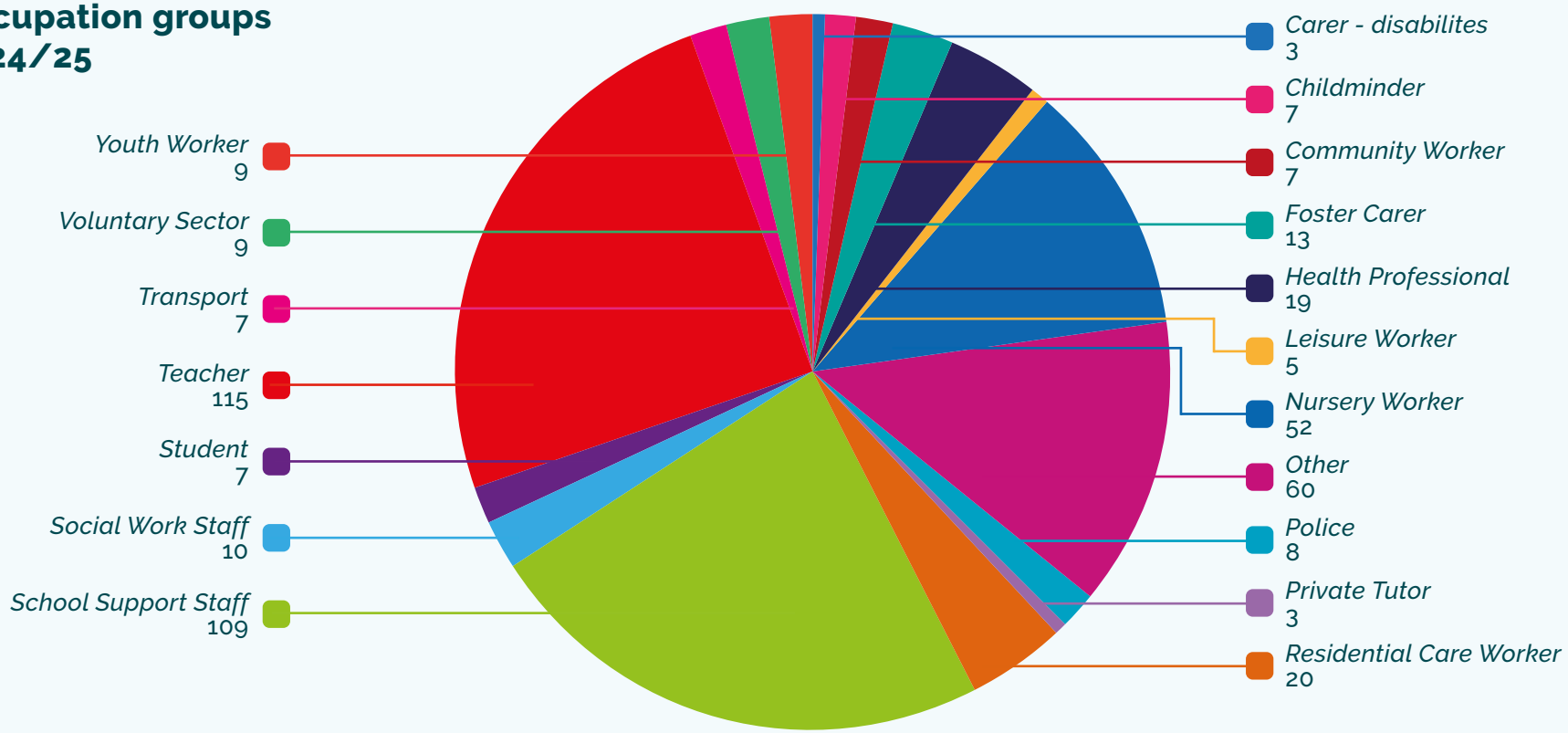
For 2024/25 the category with the highest number of contacts related to physical harm (31.3%) with conduct (28.7%) being the second highest. Concerns in private life had the third highest number of contacts (19.6%). These categories mirror those of previous years. 'Other' types of concerns set out in the table below are for those matters that do not fall under the defined categories of harm. It includes, for example, notification of unregistered educational settings, seeking advice regarding the behaviour of students, information requests for references, Ofsted contact seeking information prior to inspections.



EVIDENCE

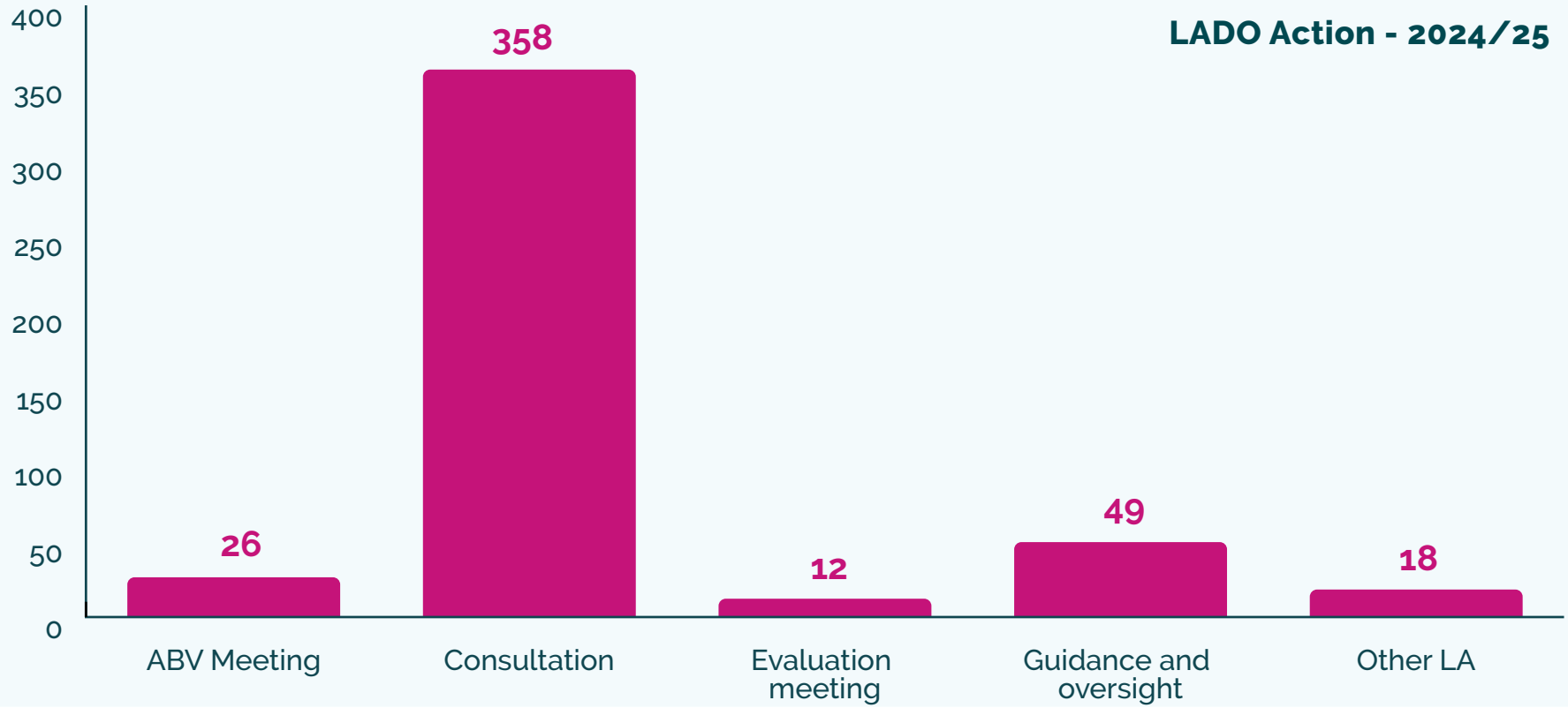
The occupations with the highest number of contacts related to teachers (24.8%), school support staff (23.5%), and nursery workers (11.2%) which remains consistent with 2023/24 figures. This consistency is likely attributable to the higher ratio of children to staff within the education sector.

Occupation groups 2024/25



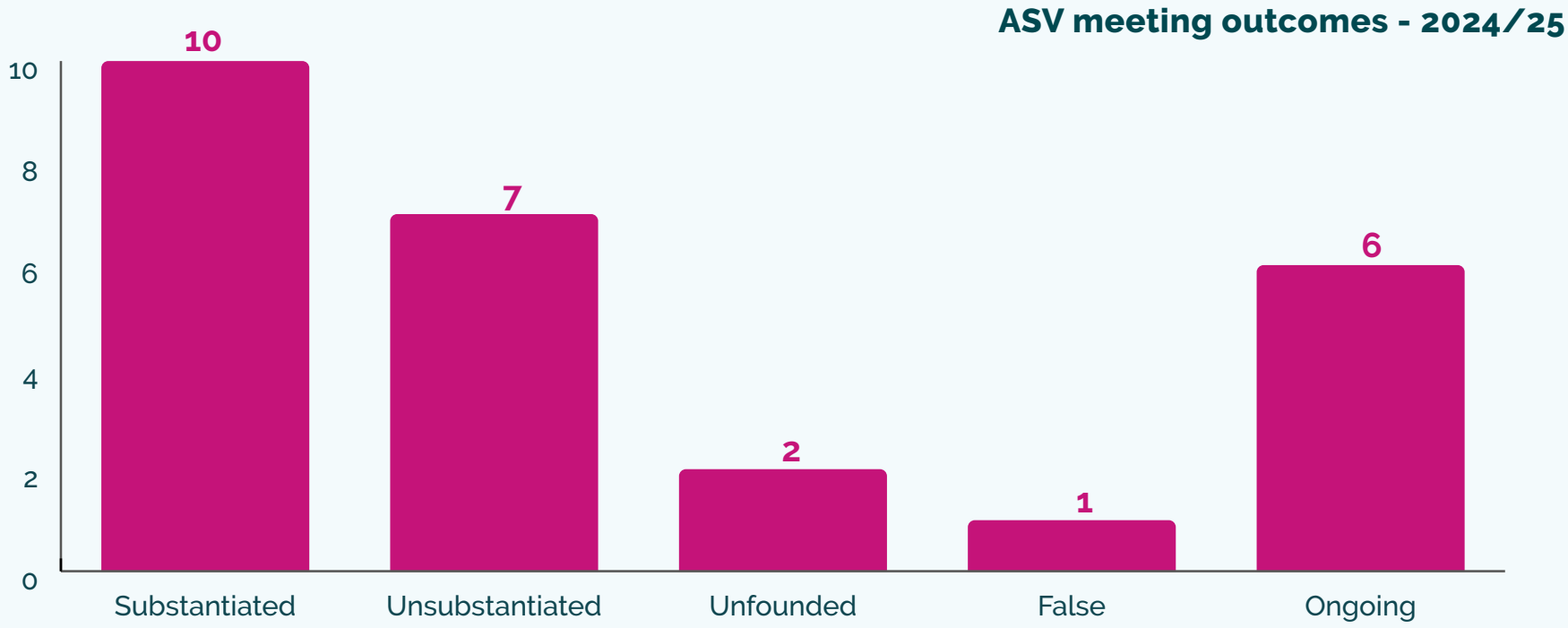
EVIDENCE

Consultations remained the highest demand for the LADO service in 2024/25 accounting for 81%, which is an increase of 23% compared with 2023/24. This could in part be attributable to the overall increase in contacts, but also to DSLs and Headteachers becoming more familiar with the LADO process - requiring less guidance when notifying of a concern or allegation. There has been a slight increase in Evaluation meetings being held (7) and the increase in 'Guidance and Oversight' and 'Other Local Authority' could all be attributed to the overall increase in contacts.



IMPACT

Most cases considered at ASV meetings during 2024/2025 resulted in a 'substantiated' outcome. Seven out of the 20 concluded cases resulted in an 'unsubstantiated' outcome. The fact that the concern/allegation was not substantiated does not suggest that these matters did not need consideration under the LADO procedures. It only indicated that evidence was lacking to support the allegation/concern or could not disprove it. Only one case resulted in a 'false' outcome. The cases that are 'ongoing' refers to awaited outcomes of Police investigations, some of which relate to suspicion of possession/distribution of indecent images of children which involves long waiting times due to the forensic analysis of electronic devices required and delays owing to the volume of such cases.



EVIDENCE

In terms of LADO outcomes, internal investigations completed by settings/employers made up 44.27% (42.09% for 2023/24) of the total outcomes with the second highest being information sharing at 16.41% (15.57% for 2023/24). Similar to 2023/24, for the period of 2024/25 'advice only' was the third highest outcome at 9.93% (12.16% for 2023/24). Again, a strong statistical consistency exists year on year with the outcome of LADO contacts remaining unchanged.

LEARNING

The Hackney Education (HE) Safeguarding in Education Team runs an extensive training programme throughout the year including Safeguarding and Child Protection training for HE 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.

LEARNING

The Hackney LADO actively participates in peer discussions with colleagues to share knowledge, trends, and best practices to promote continued learning and development of the service in line with peers. The LADO is also a regular attendee at the London LADO Network to keep abreast of themes and practice dilemmas, to contribute to policy and guidance development, and to be part of the collective voice when challenges are needed to partner agencies.

IMPROVEMENT

Every year, the Local Authority Designated Officer (LADO) will attend the Headteachers' Termly Briefing to share key statistics and insights from this report. The aim is to keep school leaders informed and up to date on safeguarding and the LADO process. A clear need for better understanding of the LADO's role and procedures has been identified among Children's Services staff. To address this, the LADO will provide training sessions for these teams and will also continue to offer tailored training to individual settings as needed. The LADO's internal recording strategy is currently under review, with the goal of finalising a policy that ensures all records are kept accurately and efficiently. Finally, the LADO will continue to work in partnership with the London LADO Network, helping to develop Professional Standards and finalise drafted procedures that are awaiting approval.

Learning & Improvement

Key Messages for Practice

Over the past few years, the CHSCP has undertaken a substantial range of activity seeking to identify lessons for practice improvement. Through its learning and improvement framework, many have been captured. That said, from all this work, we have seen a range of common themes that should remain as priorities for our front-line practitioners.

SAFEGUARDING FIRST

The need for practitioners to adopt a 'Safeguarding First' approach to their practice has been a key theme for the partnership since the publication of its review into **Chadrack Mbala-Mulo**, and that involving **Child Q**. This is not a particularly complicated message, but one that needs to be routinely reinforced, along with the CHSCP's principles of children being seen, heard and helped. Put simply, whatever your role or whatever policy or procedure you might be following, you should always be considering the safeguarding needs of a child. Their safety and welfare should always be your first priorities and whilst 'safeguarding is everyone's responsibility', that doesn't mean you can rely on someone else to act. You need to.

Applying this approach to practice is less about reading pages and pages of guidance, but more about the culture of how you and your agencies operate. Developing a culture that places the safety of children at the heart of our system is the first step we all need to take. It's also something that our leaders need to promote rigorously. If they aren't talking about safeguarding as a priority, those on the front-line won't be either. The next step is acknowledging that whilst safeguarding might be one priority amongst many for you, you need to make a concentrated effort to always base your decisions and actions on the best interests of the child. Develop your skills and confidence, engage other practitioners and access the support from your supervisors. 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

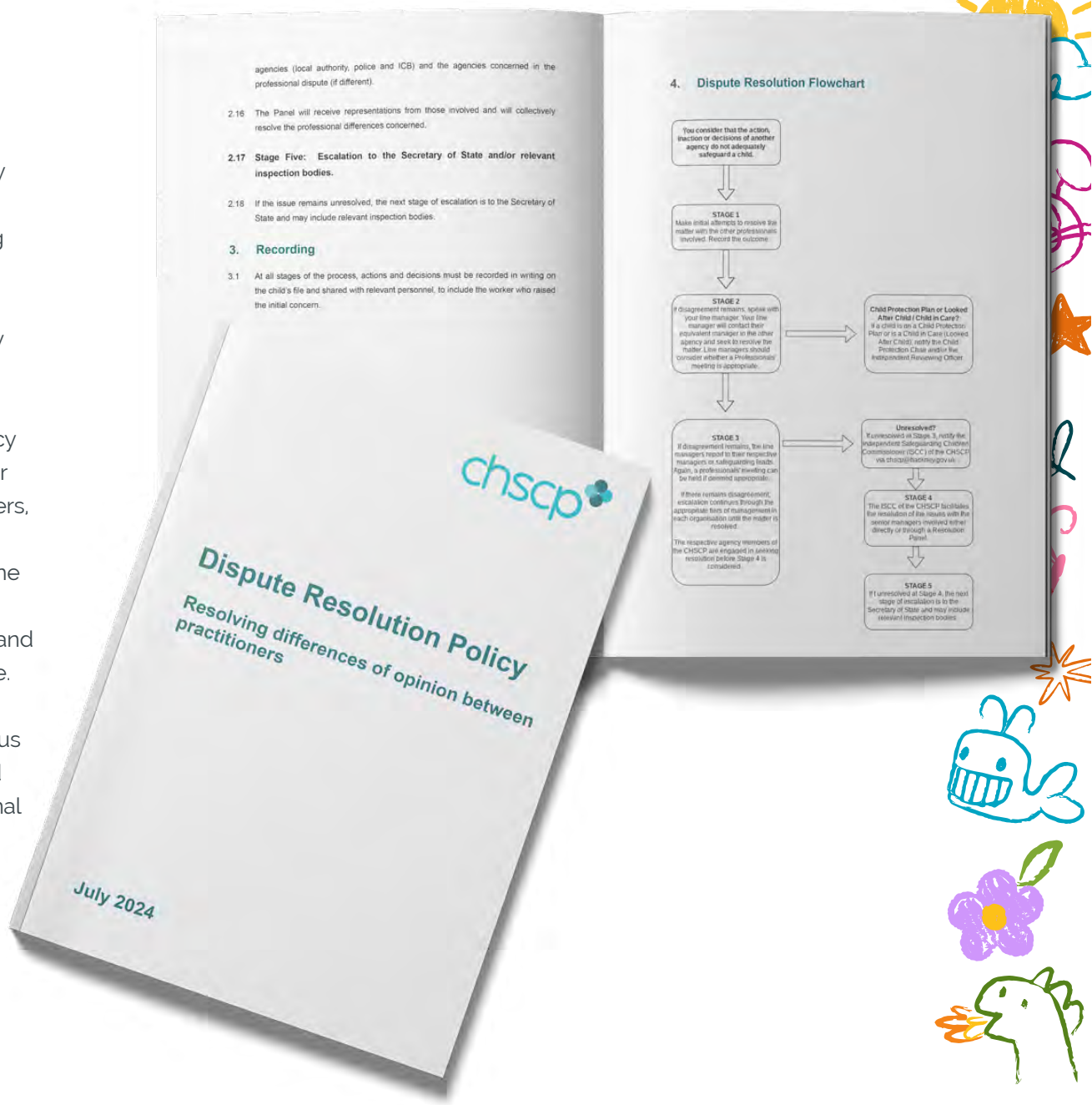
Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described at the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation 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 several 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 Dispute Resolution Policy.



SAFER - The Golden Rules of Safeguarding

We expect all safeguarding practitioners to be confident and competent in their ability to identify, assess, analyse and manage risk confidently. We want them to have an unswerving focus on the basics. We must get this right - every time. As a minimum, this means all safeguarding practitioners operating to the CHSCP's Golden Rules of Safeguarding

Sharing Information

Good information sharing is vital when professionals are worried about people and want to help them. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Learning from Serious Case Reviews reinforces the fact that both children and adults can suffer significant harm or death when professionals fail to share information or fail to share it in a timely way. Good communication and appropriate information sharing between professionals is therefore a critical element of effective safeguarding practice.

Assessing (& Managing) Risk

When safeguarding children, practitioners working in the City of London and Hackney need to know what to look for and what to do if they think they've seen it. This means practitioners having a good understanding of the signs and symptoms of abuse and neglect and a working knowledge of the local threshold tool. It also means practitioners knowing where to seek help (for example, from their DSL) and how to report any concerns. Importantly, practitioners from both children and adult services need to engage in our multi-agency arrangements, and when needed, contribute to any multi-agency meetings or processes tasked with helping and protecting children.

Focus on the Child

Maintaining a focus on the child and hearing their voices is paramount to our local arrangements. In all our work, we need to listen and think carefully about what children are saying and what meaning this has for them. We need to try and understand their lived experience and what life is like through their eyes.

Escalation

Differences of 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. Don't be afraid to voice them. 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.

Recording

We should all recognise the importance of good recording. The ability to maintain records that are focused, accurate and evidence professional judgement is a key skill we expect all practitioners to have. Good recording can help spot themes, patterns and trends in a child's care (such a neglect). They are a record for the child and an audit trail of your practice.

Reviews of Practice

Local Child Safeguarding Practice 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) and were transitioned to this alternative model in July 2019. As set out in statutory guidance: *'Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings.'*

EVIDENCE

- During 2024/25, two Serious Incident Notifications were made to the Child Safeguarding Practice Review Panel, both of which were subject to a Rapid Review by the CHSCP. From the notified cases, no Local Child Safeguarding Practice Reviews (LCSPRs) were commissioned.
- No Serious Incident Notifications were made relating to cases in the City of London.
- Three other Hackney cases (not meeting the criteria for notification) were also considered by the Case Review Sub-Group.
- Two of these cases resulted in a Rapid Review and one LCSPR was instigated.
- In line with revisions made to Working Together to Safeguard Children 2023, one notification was made following the death of a Care Leaver. Whilst a Rapid Review was held this did not result in a LCSPR.
- Two LCSPRs (Case A and Child V) were published during the reporting period.
- Full details of all the reviews published by the CHSCP are available HERE.

Statement (3) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Terms of Reference - Mossbourne Victoria Park Academy

Statement (2) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Statement (1) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Child V Audio Summary

Child V Summary

Local Child Safeguarding Practice Review - Child V

Case A Audio Summary

Case A Summary

Rapid Reviews

Following notification of a serious incident to the Panel, the CHSCP will always initiate a Rapid Review. The aim of a Rapid Review is to:

- gather the facts about the case, as far as they can be readily established at the time.
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- consider the potential for identifying improvements to safeguard and promote the welfare of children.
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

Once complete, the outcome of a Rapid Review and the CHSCP's decision about whether a review is appropriate is shared with the Panel. The CHSCP's analysis will include whether it thinks the case raises issues which are complex or of national importance such that a national review may be appropriate. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to send a Rapid Review to the Panel. For all Rapid Reviews, whilst reports of these are not generally published, any actions arising from them will be developed and tracked by the Case review Sub Group.

IMPACT

For the first Rapid Review undertaken in 2024/25, TUSK briefings and video guidance previously produced by the CHSCP were disseminated focussing on information sharing, the DfE's updated guidance and the issue of consent. An action to reintroduce "Difficult Conversations" training is being taken forward by the TLD Sub Group. A themed session to discuss the threshold for triggering an LCSPR was placed on the agenda of the Case Review Sub Group.

IMPACT

Following the second Rapid Review, to enhance practitioner awareness, the CHSCP developed a Partnership Briefing on child protection enquiries, detailing what they involve and differentiating between single and joint agency investigations under section 47 Children Act 1989. Additionally, CHSCP material on strategy discussions has been relaunched to clarify their purpose, attendees, and information sharing standards.

A key focus has been integrating anti-racism into practice, with the strategy discussion template having been reviewed and amended to strengthen its section on anti-racist practice and considerations. To improve understanding of neurodiversity and its impact on children and parents, the CHSCP has explored options for including relevant training courses within its program.

The CHSCP has also committed to identifying and supporting young carers by promoting awareness of Young Carers and relevant policies, procedures, and guidance via its website and TUSK briefings (newsletter). Finally, to ensure practitioners operate within their legal authority, available guidance issued under Working Together to Safeguard Children 2023, the London procedures, and local guidance has been reviewed to confirm sufficient description of respective duties and powers.

Alongside these multi-agency recommendations, individual agencies have also progressed a range of learning. For example, Homerton Healthcare NHS Foundation Trust has focused on enhancing awareness and teaching on caring for neurodiverse clients by sharing further learning and resources. They also aim to embed a trauma-informed approach in service delivery, which involves working with staff to provide trauma-informed care, considering specialist teaching sessions, and holding webinars on Trauma-Informed Care (TIC).

Furthermore, the Trust is improving awareness of police escalation pathways. This has involved establishing regular meetings with the police, developing tips for health and police staff on information sharing in safeguarding cases, and holding a learning event in September 2024. They have also been working to improve understanding of the purpose of Strategy Meetings and the roles and responsibilities of multidisciplinary teams (MDTs), including the impact of information sharing and language used by different agencies, through developing scenarios for simulation exercises.

IMPACT

For the third Rapid Review, a short briefing note about the change in policy and process for reporting care leaver deaths was produced and sent as a letter from the ISCC to partner agencies. An action covering how care leaver information can be integrated into the CPIS system is being pursued.

EVIDENCE

The fourth Rapid Review process involved the concerns raised about Mossbourne Victoria Park Academy. The LCSPR into this case remains ongoing at the time of writing. The review's terms of reference and statements issued by the ISCC can be found HERE.

Local Child Safeguarding Practice Reviews

One Local Child Safeguarding Practice Review was triggered in 2024/25 involving Mossbourne Victoria Park Academy. Two LCSPRs were published (Child A and Child V). Two others were ongoing (Child F and Child W). Published reviews are available on the CHSCP website HERE.

With regards to the Child W review, a final report has been completed by the independent author, and this has been shared with the Child Safeguarding Practice Review Panel. The CHSCP has determined this report shouldn't be published and discussions continue with the Panel on this issue. Our intention remains to release a summary of this case. A final draft of the Child F has also been completed by the independent author, and this will be published shortly. Whilst Case A was referenced in the 2023/24 report, it is included again in this year's report.

CASE A

In 2023, Mr A pleaded guilty to over 30 sexual offences involving both children and adults. He was given a custodial sentence, made subject to notification requirements and issued with a court-imposed Sexual Harm Prevention Order. His crimes included sexual assault, engaging in sexual activity in the presence of a child, making indecent photographs of a child, voyeurism, exposure and up-skirting. Without question, the nature and scale of Mr A's offences are both shocking and deeply disturbing. However, they weren't his first. In 2014, Mr A was found guilty of possessing indecent images of children and given a suspended sentence. At the time, notification requirements were put into place alongside a five-year Sexual Offences Prevention Order. Mr A participated in an internet sex offender programme, unpaid work and was monitored by a local Jigsaw team from the Metropolitan Police Service. Whilst subject to this supervision, Mr A became the father of two children. However, there was no record of him telling the police or the Probation service about their births. Furthermore, despite ongoing monitoring and there being intelligence that Mr A had a child, it was not until late 2018 that a referral was made to children's social care. By this time, the eldest child was two and a half years old, and the youngest, five months. A statutory social work assessment was subsequently triggered by children's social care, although this resulted in no further action and the case was closed. Supervision of Mr A remained with the police until the ending of his notification requirements in 2021.

The LCSPR into this case was commissioned to examine how local agencies managed and mitigated the risks posed by Mr A to his children, other family members and the wider public. It was undertaken by the CHSCP's ISCC (Jim Gamble QPM) and its Senior Professional Advisor (Rory McCallum). It makes five findings and five recommendations for improving practice.

The full report can be read HERE.

A Short Audio Briefing is available HERE.

LEARNING

Finding 1: The management of Mr A via the Level 1 MAPPA arrangements was insufficiently robust in terms of professional curiosity, rigour and authority. Ineffective investigation resulted in missed opportunities to identify risk and intervention lacked any clear focus on the paramountcy of the child.

Finding 2: Practitioners in children's social care were too optimistic when engaging the family. There was little evidence of thoroughness, reflection or an understanding about the risks posed by child sex offenders, and too much emphasis was placed on the police assessment of risk. Opportunities were missed to bring the partnership together to develop clear safety planning and to ensure that everyone was sighted on this family's circumstances.

Finding 3: There was evidence of good practice by the health visitor and nursery manager. Both showed initiative through the health visitor working directly with Ms R on strategies for safety and the nursery manager seeking out further information.

Finding 4: Practitioners responsible for Level 1 MAPPA cases are potential single points of failure. The absence of the need for formal multi-agency meetings, the reliance on professional judgement and the operational pressures on both the police and probation, means it is sensible to consider widening the cohort of practitioners who are automatically alerted to RSOs (i.e. beyond those agencies with access to ViSOR). Whilst not advocating for unfettered information sharing, engaging key partners could help with monitoring and the identification of risk.

Finding 5: Practitioners need to be mindful of the range of research findings about viewers of indecent images of children. Overreliance on messages about low recidivism rates or offending trajectory can lead to superficial conclusions, risk being misinterpreted and false reassurance. In all circumstances, individualised assessments are required that engage those with sufficient expertise in this field of work.

IMPROVEMENT

Recommendation 1: In all cases where known child sex offenders are having contact with children, the MPS (specifically MASH police officers (or equivalent)) should ensure that referrals are always made to children's social care.

Recommendation 2: Both the MPS and the London Safeguarding Children Partnership should review their guidance on the risk management of known offenders and as required, strengthen the clarity on triggering a Section 47 enquiry when known child sex offenders are believed to be in contact with children.

Recommendation 3: The MPS should consider the sufficiency of its arrangements covering the disclosure of an offender's details to third parties. Where necessary, guidance should be updated to specify who is responsible for making third-party disclosures and who is expected to attend relevant multi-agency meetings where disclosures might need to be considered (such as strategy discussions). The MPS should seek reassurance that its processes neither delay nor inhibit its duty to protect children from potential harm.

Recommendation 4: As part of its national review into Child Sexual Abuse in the family, the Child Safeguarding Practice Review should form a view on the potential for the secure and routine information sharing of Level 1 MAPPA Offenders with other key agencies, particularly General Practitioners.

Recommendation 5: The CHSCP should commission context specific training on child sex offenders and include this as part of its annual programme open to all practitioners within the City and Hackney.

IMPACT

The CHSCP Multi-Agency Action Plan for LCSPR Case A has made progress across several recommendations, which are rated using a RAG (Red, Amber, Green) system. Learning on this case has been disseminated via the CHSCP's TUSK briefing.

With regards to Recommendation 1, which requires the MPS to ensure that referrals are always made to children's social care in cases where known child sex offenders have contact with children, the status is "GREEN - Complete". Reassurance has been sought from the CE BCU in this respect and followed up through communication from the ISCC.

Regarding Recommendations 2 and 3, which involve the MPS and the London Safeguarding Children Partnership (SCP) reviewing their guidance on the risk management of known offenders and the arrangements for disclosure, both are marked "AMBER – In progress". Letters were sent to both organisations by the ISCC. The London SCP has acknowledged the proposals and is considering them through its editorial board.

With regard to Recommendation 4, which asks the Child Safeguarding Practice Review Panel to consider the potential for routine information sharing of Level 1 MAPPA Offenders with other agencies, this is rated as "GREEN – Complete". At a meeting between the ISCC, the SPA, the Chair of the national Child Safeguarding Practice Review Panel and a Panel member, a briefing was given on a national review being published, with reassurance provided that the focus on information sharing and the functions of MAPPA would be considered within this piece of work.

For Recommendation 5, which tasked the CHSCP with commissioning context-specific training on child sex offenders, the status is "GREEN - Complete & Ongoing". The CHSCP commissioned a specialist provider to deliver bespoke training to social workers and police officers, alongside a more general course. More training is being commissioned in 2025/26.

Finally, regarding the dissemination of learning, the CHSCP has completed several actions, including publishing the LCSPR report on its website, highlighting the learning in a "Things You Should Know" briefing, disseminating learning to the CHSCP Training, Learning and Development Sub-Group, and adding the report to the NSPCC repository. These actions were all listed as "Complete" as of July 2024.

CHILD V

Child V, a White female child, died in January 2023 at the age of seven. She had a range of complex health needs and multiple diagnoses. In the years preceding Child V's death, there had been significant contact with practitioners from health and children's social care due long-standing concerns about neglect and Child V's health and wellbeing. The review was authored by Sophie Humphreys OBE. It made five findings and four recommendations for improving practice.

The full report can be read HERE.

A Short Audio Briefing is available HERE.

LEARNING

Finding 1: An insufficient focus on the cumulative harm that Child V was being exposed to meant that risk was never fully understood or agreed across the multi-agency network. This resulted in practice lacking both the authority and timeliness to ensure that Child V was effectively helped and protected.

Finding 2: Insufficient management grip, knowledge deficits and the significant number of services involved with Child V meant there was an ambiguity about risk, case ownership, roles, responsibilities and communication. The multi-agency processes in place to help practitioners coordinate intervention were largely ineffective in this complex case.

Finding 3: The main inhibitor to effective engagement in this case was Child V's father. Despite substantial efforts by the many practitioners involved, his entrenched views on the treatment and care for Child V meant that cooperation and change was unlikely. Given the implications for Child V, this should have prompted a more robust response to ensure Child V's needs were met and risk mitigated.

Finding 4: Notwithstanding the significant efforts of many practitioners, the priority afforded to Child V's needs was diluted by repeated attempts to influence a change in parental behaviours. This approach continued even when the evidence showed this was unlikely to be successful. Whilst safeguarding practice should always be characterised by empathy and a sensitivity, the safety and welfare of children must always be the primary drivers of decision making and action.

Finding 5: Notwithstanding the complexity of this case, care proceedings were neither timely nor effective in bringing about a material change for Child V.

IMPROVEMENT

Recommendation 1: Safeguarding partners should seek to strengthen their arrangements for how neglect is understood, identified, assessed and planned for across the partnership. Alongside ensuring that practitioners are alert to the cumulative impact and wide-ranging sources of neglect, there should be a specific focus on children with disabilities and complex health needs as part of this work.

Recommendation 2: The Local Authority and NEL NHS ICB should review the effectiveness of its arrangements governing multi-agency practice with children with disabilities and complex health needs. Reassurance should be sought that these arrangements are explicit about roles and responsibilities as they relate to the assessment, planning and review of risk. The frequency and focus of multi-agency meetings that bring the network together should be sufficiently robust to ensure drift and delay in casework is avoided.

Recommendation 3: The CHSCP should issue practice guidance and review its offer on delivering local multi-agency training aimed at working with parents / carers where their engagement is reluctant or sporadic.

Recommendation 4: The Local Authority should review the existing arrangements for how independent expert reports are commissioned. Whether commissioned as part of ongoing proceedings or in other circumstances, the Local Authority should seek reassurance that these arrangements are sufficiently robust to ensure these reports are properly scrutinised and challenged.

IMPACT

The CHSCP Multi-Agency Action Plan for LCSPR Child V has made progress across several recommendations, which are rated using a RAG (Red, Amber, Green) system. Learning on this case has been disseminated via the CHSCP's TUSK briefing and included in a podcast from RISE.

With regards to Recommendation 1, the status is "GREEN - COMPLETE". The CHSCP already has guidance in place, a range of tools available for practitioners and a rolling training program on neglect continues. The team plans to engage with the London Safeguarding Children Partnership's neglect workstream (this is a London priority for 25/26) to see if any further earning or initiatives can be accrued.

Regarding Recommendation 2, this action is rated as "GREEN - action closed". Significantly, clarity around the roles and responsibilities of practitioners helping and supporting families will be addressed as part of the wider reforms being implemented through the Families First Partnership Programme.

In terms of Recommendation 3, concerning the development of practice guidance and training for working with families where engagement is reluctant or sporadic, this is also "GREEN - COMPLETE". A specific Partnership Briefing has been developed and communicated, and the TLD Sub-Group is actively planning to reintroduce training on "Difficult conversations".

With regard to Recommendation 4, the Local Authority has clear arrangements in place for commissioning independent expert reports. Furthermore, the learning from this review has been cascaded, with a focus on ensuring ongoing professional curiosity and challenge takes place where such reports do not align with the plans of the LA. Whilst 'expert' reports are often requested by the LA itself or instructed (at Court), they should never be judged as 'superior' to the expertise held internally or accepted automatically where there are differences of opinion.

CHILD Q

The CHSCP's multi-agency action plan in response to the Local Child Safeguarding Practice Review and the Update Report for Child Q was last updated in August 2025. As with other action plans, this is being overseen by the CHSCP's Case review Sub Group. By way of summary, several key recommendations remain in progress / awaiting updates.

PACE Code Revisions: Several recommendations depend on the outcome of a statutory consultation on revisions to the Police and Criminal Evidence Act 1984 (PACE) Code of Practice. These include updating police guidance on the engagement of appropriate adults and defining the safeguarding needs of children during strip searches. The consultation response to the Home Office was drafted in June 2024, but the actions remain in progress pending the outcome of this consultation.

CHSCP Surveys and Engagement: The CHSCP was tasked with launching borough-wide, age-appropriate surveys to gather children's views on safeguarding, with a focus on themes from the Child Q review, such as feeling safe in school. Whilst some of this activity is being reflected in the LCSPR involving Mossbourne Victoria Park Academy, work will be taken forward in 2025/26. Progress has been hampered by capacity limitations within the CHSCP team.

DfE Guidance on Strip Searching: The Department for Education (DfE) previously confirmed with the CHSCP it was reviewing its guidance on strip searching in schools following a request by the CHSCP that it better emphasises the "very exceptional circumstances" in which such an action would be appropriate. This work was reported as being considered alongside the Home Office and is still in progress.

BCU Commander Recruitment: This recommendation was for the MPS to develop mechanisms for local representatives to be included in the recruitment processes for BCU Commanders across London. This recommendation is aimed at strengthening accountability and improving community relationships. As of August 2025, there has been no further update on this action.

Auditing

CHILD SAFEGUARDING STATEMENTS

Developed from a model in operation in Ireland, Child Safeguarding Statements are intended to enhance an organisation's ability to identify potential risks, develop policies and procedures and review whether adequate precautions have been taken to eliminate or reduce these risks. They require sign off from Chief Executives / the most senior person within an organisation. This reinforces the need for these key roles to be directly engaged in and sighted on their organisation's strengths and weaknesses. Following a successful pilot and reflecting on feedback from participating agencies, a wider programme engaging all Relevant Agencies and Named Organisations in City and Hackney was agreed and in progress across 2024/25. Capacity issues in the CHSCP Team have meant this initiative has been temporarily paused.

Full details of the Child Safeguarding Statement programme can be found within the Learning and Improvement section of the CHSCP website. This webpage contains a live index of organisations and their completed Child Safeguarding Statements. Whilst not an official accreditation, this will provide a public directory of agencies that have cooperated with the CHSCP's written safeguarding arrangements.

MULTI-AGENCY CASE AUDITS

The Multi-Agency Case Auditing programme has been developed to focus on specific areas of the safeguarding system. This has allowed multi-agency partners to adapt 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.

In 2024, the CHSCP undertook a multi-agency case audit of cases involving 'Tier 3.5' cases of children with mental health needs. The cohort included children with ASD. The following provides a summary of the audit's findings. By way of context, the audits identified known demand pressures and the impact on aspects such as timeliness and waiting lists. These pressures fully recognised by our local system, with children's mental health remaining on the CHSCP's risk register. That said, a good range of mitigations are in place and there is ongoing focus, effort and innovation across the partnership.

EVIDENCE

Practitioners are generally alive to issues of risk and need and use internal pathways to escalate and report concerns. There is a focus on identifying and addressing the lack of appropriate educational provision for vulnerable children. Efforts continue to be made to understand the challenges of exclusions and the work of the REU. The audit also highlighted thoughtful approaches by practitioners in capturing the voice of children and young people and integrating it into plans. There is a focus on engaging the wider family and family network in planning. Good practice was seen in giving children and young people the space to be seen by themselves and picking up on nonverbal signs of communication. Schools continue to provide substantial in-and-out-of-school support for children. Agencies are actively trying to make a difference and support children.

EVIDENCE

Mental health issues in children can often be misunderstood or minimised, leading to delayed identification and intervention. There can also be the added complexity involving stigma – that can discourage some families from seeking help or acknowledging their child's needs. Early signs of mental health issues may also be misinterpreted as behavioural issues or dismissed as developmental phases – and responded to as such. This results in need being unmet, ineffective support and ultimately, poorer outcomes for children.

Positively, in the context of the cases audited by the CHSCP, there was good evidence that staff were alive to the issues and risk and need which present for children requiring mental health support. There was also evidence of internal and external pathways being used effectively by staff to report concerns and access support for children and families. Notwithstanding ongoing challenges, local support via the CAMHS Alliance and initiatives such as the Wellbeing and Mental Health Service in Schools initiative are making a difference.

The CAMHS Alliance facilitates better partnership working between different organisations and services, and ensures we deliver integrated pathways that can effectively reach more children, young people, families, schools and the wider community. The Alliance is formed by different services and partners that work across City & Hackney and deal with a range of issues, of levels of need and with specific groups of population. In this directory you can find a description of each of the services that are part of the Alliance, what they do and who is eligible to access them, as well as how to refer a young person who might need their services.

EVIDENCE

The audits showed good practice with two 'pilot' schools engaging multi-disciplinary teams (MDTs). These schools are identifying challenges for children early, putting in school interventions, with the pathways to the MDTs resulting in wrap around provision for children and families. Screening at the front-door of children's services is also focusing on mental health needs in the context of early help.

The Hackney Child Wellbeing Framework and the City of London Threshold of Needs tool continue to help guide practitioners on the most appropriate response for presenting levels of need. Needs relating to the emotional health, wellbeing and behaviour of children are explicitly articulated.

EVIDENCE

The audits evidenced that practitioners from key agencies, including schools, were attending regular multi-agency meetings for these children. More broadly, there is evidence of ongoing scrutiny on issues relating to attendance that continue to help shape policy and support for children. That said, there is a need to better understand the challenges that children face in this context and the sufficiency and efficacy of interventions.

EVIDENCE

The audits demonstrated a thoughtful approach to gathering the voice of children and young people and ensuring these were being integrated into any plans. Older young people had been given the space to be seen by themselves or with a parent / carer if they were particularly anxious. There was also evidence that the wider family network was engaged during the planning process. A training package is being developed by Homerton Healthcare to support professionals in documenting the voice of the child and really understanding what this means and looks like. The training is intended to be open access and could be further developed with a multi-agency focus in future.

EVIDENCE

Effective support requires collaboration among multiple agencies and stakeholders, including parents, teachers, healthcare providers, and children's social care. Poor communication and fragmented systems make coordination challenging. Children in foster care or those experiencing family instability face unique difficulties due to frequent transitions between caregivers and providers. Whilst noting the ongoing challenges around waiting lists, provision and demand, the audits demonstrated that good support is being made available, including that within schools. There was good evidence of the commitment of agencies trying to make a difference and support individual children with mental health needs.

Hackney's Re-Engagement Unit (the REU) is a service that supports families and schools if a child is finding engaging in school difficult. The aim of the service is to enable all children to be happy and to achieve. The REU is made up of workers from many different professional backgrounds: teachers; learning mentors; family support workers amongst others. The REU is also supported by a clinician from the Child and Adolescent Mental Health Service (CAMHS). Find out more information here.

EVIDENCE

The audits identified recent changes in the template for strategy discussions are helping ensure anti-racist practice is better considered as part of this process.

EVIDENCE

Transition periods are known for being a risky period with escalating issues. The audits highlighted the importance of persistent practitioners who keep a focus on the child and can professionally challenge colleagues and the system to advocate for the needs of the child. From a health perspective - as the holders of central health records, GPs were noted as being very important in the transition process. Of note, one of the audits reviewed demonstrated excellent practice in expediting a child's assessment for ADHD during a period of transition.

LEARNING AND IMPROVEMENT

Information sharing was identified as an issue in several areas, with concerns about timeliness, clarity of consent, and lack of follow-up. There can be confusion or anxiety among frontline professionals about expectations around information sharing. Issues were also raised about timeliness and waiting lists for access to services, particularly for appropriate residential and educational provision. There is a need for better joint working and a more integrated approach, especially for children who do not neatly fall into CP, LAC, or CIN categories. The audit highlighted a lack of clarity around the remit and responsibilities of each agency, particularly concerning exclusion processes and pathways.

LEARNING AND IMPROVEMENT

Practice issues were identified about the regularity of reviews and meetings, and agencies being kept in the loop. The audit identified a gap in the system for children with complex needs and families who struggle, with a lack of structure for routine and regular multi-agency working. There is a need for greater consideration of child and family identity, including ethnicity, sexuality, and gender. While some agencies have grasped this well, others have not, highlighting a need for greater awareness and training. Transitions, such as moving from primary to secondary school or changes in social workers, were identified as risky times with potential for escalating problems. The audit highlighted a need for greater attention to transitions and ensuring continuity of support during these times.

LEARNING AND IMPROVEMENT

Ongoing challenges with language barriers and accessing interpreters with the right dialect were identified. This can impact the timeliness of meetings and the ability to engage parents effectively. Overall, there is a need for greater understanding and awareness of the health architecture and system among partners. The audit highlighted a need for a more robust and comfortable system for professionals working with children and families. There is a lack of awareness on what is happening in the space of attendance issues and their link to other risks.

LEARNING AND IMPROVEMENT

Identification and Assessment or Risk and Need: The audits evidenced increased confidence is needed at an individual and agency level around the sharing of information. They noted improvements can be made where agencies are being asked for information by statutory agencies – such as children's social care. On occasions, agencies are not being advised of the outcome of a referral, and this is not being followed up by them. Previous audit rounds have also noted that agencies had sometimes not been provided the context of concerns when being asked to share information. This meant they were unable to make a rational judgement on exactly what information should be shared.

The Department for Education has released updated guidance which is much sharper at emphasising the lawful basis for sharing information when there are safeguarding concerns.

The audits practitioners need for practitioners to remain alert to the different agencies involved with a child / family and who else might need to be engaged in the assessment of need and planning for support.

The audits also found that there can be variability in practice as it relates to the identification of lead professionals and how activity is coordinated for children within this cohort – particularly where support is not part of any statutory intervention. In these circumstances (i.e. early help), cases can become more reliant on individual capacity and judgment as opposed to systems and processes. There can also be a lack of understanding and assumptions made about which agency is 'leading' and has 'responsibility' for a case. The issues relating to lead professionals have featured in previous reviews undertaken by the CHSCP and are subject to ongoing consideration both locally and nationally.

The audits evidenced a need to further consider exclusions in the context of children who might not be able to access services rapidly and who go on to exhibit challenging behaviours in school. Due to the nexus of exclusion with missing children and the escalation of risk, this is an aspect that requires ongoing scrutiny via the CHSCP's arrangements.

The importance of using interpreters was recognised in the audits, although it was noted that a lack of translators who both have the right dialect and also understand mental health, vulnerability and additional needs, could inhibit the ability to practice as well or as timely as needed.

SINGLE AGENCY AUDITING

Partner agencies of the CHSCP have continued to operate a variety of single agency quality assurance frameworks to maintain oversight on safeguarding and promoting the welfare of children and young people. Examples of audits undertaken are below:

EVIDENCE AND LEARNING

In April, the **City of London Corporation's** Quality Assurance template, process and review quality was scrutinised by the East London Peer Audit Group. The group review the most recent round of 14 reviews completed within the Practice Assurance Review and commented on the strengths and areas for development in relation to the tools used and process. This was a helpful exercise which has led to an updating of the practice review template and questions, is informing a more consistent and robust moderation process, and supported the updating of the QA framework. The monthly Quality Assurance Recommendation Tracking and Impact meetings continue to ensure that the learning loop is complete, and we can be assured that recommendations have been completed and measure the impact of these on improving outcomes for children and families.

EVIDENCE, LEARNING AND IMPROVEMENT

Across **Hackney Children and Families Service**, an impressive 85% of learning conversations on special educational needs and disabilities (SEND) were rated as either Good or Outstanding. This positive trend was also evident in a follow-up review by Practice Development Managers, where 58% of files had improved to a Good rating, and two cases specifically moved from Requires Improvement to Good, demonstrating that audit actions are effectively driving change for children.

Positive practice was seen in several other areas as well. The Multi-Agency Safeguarding Hub (MASH) received strong ratings for its feedback to referrers, with 39% of dip samples rated Outstanding and 43% rated as Good. Practice with Children in Need was rated 88% Good or Outstanding, while practice for Looked After children was rated 100% Good. Furthermore, audits of DAIS (Domestic Abuse Intervention Service) practice were 100% Good, highlighting that client history and vulnerabilities were consistently being considered.

A collaborative audit with the Children and Families Division also yielded positive results. The audit of Child and Adolescent Mental Health Services (CAMHS) found that 93% of assessments **clearly identified and captured children's needs**. Similarly, audits of Young Hackney highlighted the **clarity of pathways** and **access to services** as a particular strength. However, within Youth Justice audits, while **family engagement, the child's voice, and identity** were identified as strengths, there is a clear need for improvement in the areas of planning and reviewing.

EVIDENCE, LEARNING AND IMPROVEMENT

During the 2024-25 period, the safeguarding team at the East **London NHS Foundation Trust (ELFT)** carried out a series of multi-agency and Trust-wide audits. These audits were prompted by key learnings from both local and national case reviews. The findings, insights, and recommendations were shared with individual staff, managers, and the Trust Safeguarding Committee. The primary goal was to provide assurance and ensure that valuable lessons were disseminated throughout all directorates to improve practice. The audits focused on several key areas, including a "Think Family" approach, the "Voice of the Child" in adult services, domestic abuse practice and reporting, and child neglect. Across all these audits, several key themes emerged. There was a strong emphasis on **training and supervision** to improve safeguarding skills and compliance throughout the Trust. To enhance the accuracy and clarity of data, new reporting and audit tools were introduced, focusing on **data quality**. A significant finding was the need for a renewed focus on **child-centred practice**, specifically ensuring that the voice and lived experiences of children are captured effectively. Furthermore, the Trust's safeguarding policies were updated to better align with the "Think Family" and domestic abuse guidance. Finally, the use of repeat audits, supervision, and newsletters was identified as a continuous learning strategy to drive ongoing quality improvement.

EVIDENCE, LEARNING AND IMPROVEMENT

The Metropolitan Police conducted an audit of ten cases focusing on children who were witnesses to or involved in domestic abuse (DA) offences. The audit identified key lessons and has led to several changes aimed at improving practice.

One major finding was the **delay in actioning tasks** from Multi-Agency Risk Assessment Conferences (MARAC) when children were involved. To address this, any actions set at MARAC will now be sent via email not only to the Officer in Charge (OIC) and their supervisor but also to the Children's Advice and Information Team (CAIT) referral mailbox. The Connect system will also be updated. This new process aims to prevent delays caused by staff absence or leave. A second issue identified was that Connect triage cards were not consistently being completed with full information, which hindered Children's Social Care (CSC) from taking appropriate action. In response, all frontline officers will now receive **training on how to complete these cards** correctly and on the importance of professional curiosity in their work. Additionally, training on how to refer cases to MARAC has been provided to all frontline officers, with presentation slides being circulated to ensure the information is widely accessible.

EVIDENCE, LEARNING AND IMPROVEMENT

An audit was conducted by **Homerton Healthcare NHS Foundation Trust** on initial health assessments (IHA) in City and Hackney, reviewing five reports from the City and ten from Hackney. The audit's recommendations focus on improving the IHA process, from referrals and documentation to the assessments themselves. To ensure ongoing quality, the audit recommends a re-audit in 18 months and the continuation of the current caseload approach. Several recommendations address the referral and administrative processes, including the **ongoing use of existing escalation processes** for delayed IHA referrals from the Local Authority (LA). It is also advised that the consent process is clarified with the LA to ensure consistency and that **documentation of key dates** for IHA bookings is made more consistent by liaising with Looked After Children (LAC) administrative staff. The recommendations also focus on improving the quality of the assessments. It is a priority to hold **face-to-face health assessments** and to liaise with the LA to ensure relevant background information is shared before appointments. The audit also stressed the importance of having the **named social worker**, or a colleague, present at all IHAs. Finally, it was recommended that the named General Practitioner (GP) prioritises the sharing of GP and immunisation records, and that **part C of the assessment form be adapted** to reflect whether children and young people (CYP) and their carers were offered the opportunity to be seen alone and whether consent was taken for those over 16 years of age during the appointment.

EVIDENCE, LEARNING AND IMPROVEMENT

Probation continues to prioritise safeguarding through ongoing review and monitoring of safeguarding training across the region, case dip-sampling to ensure concerns are identified and addressed in line with statutory duties and a continued focus on accurate recording of safeguarding checks and responses across the PDU. These measures are essential to ensure we can evidence the safeguarding work being undertaken, maintain compliance, and uphold the safety of children and vulnerable adults.

The Voice of the Child, Family & Community

Throughout the year, agencies have demonstrated their ongoing commitment to capturing the voices of children, families, and the community as part of casework and wider engagement activity. Listening and responding to the diverse voices of the community helps to create a more supportive and responsive environment for children and families. Whilst impossible to set out all this activity within the CHSCP's annual report, this aspect was scrutinised by the Quality Assurance Sub Group early in the year. Some examples of activity are set out below:

EVIDENCE AND IMPACT

A key initiative was the establishment of the City of London Children and Families Team's Children in Care Council supper club, which began at the beginning of the year. Born from feedback about isolation among care leavers, these monthly gatherings provide a relaxed, informal setting for young people to connect, build friendships, and support one another. The positive impact is already evident, with a consistent core group of 8-10 attendees who are developing strong peer networks. This sense of community has boosted their confidence, encouraging new members to join subsequent events and reducing anxiety by sharing experiences and hearing consistent messages from professionals.

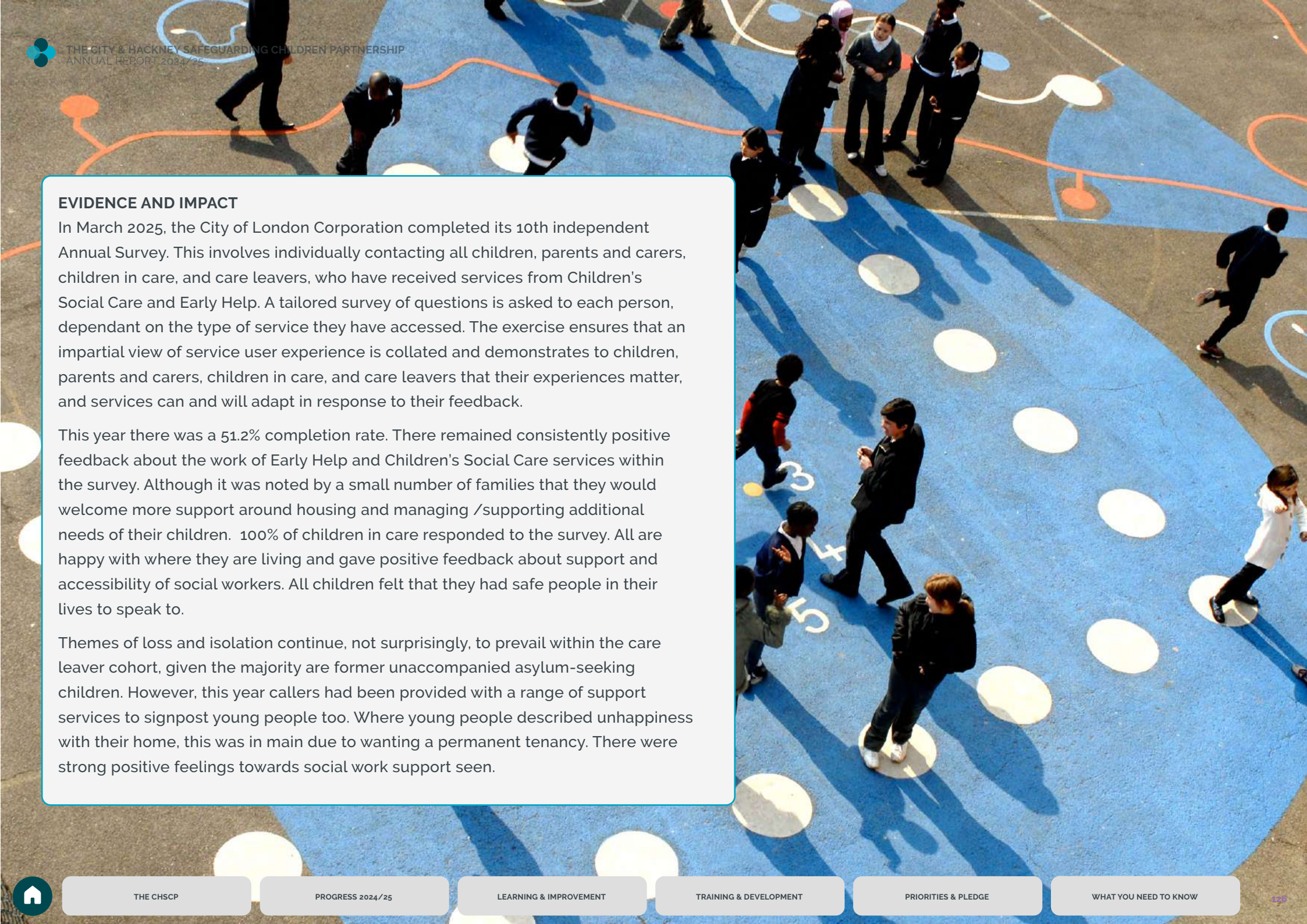
The supper clubs also revealed a need for more specific support, leading to the creation of monthly online information sessions. These sessions, facilitated by a participation worker and attended by senior staff and subject matter experts, address topics like bus passes and housing processes. This direct access to personalised information has been well received, giving young people a reliable space to get answers to their questions and feel more informed about their entitlements. In addition, we facilitated a theatre trip for our young people to see *"For Black Boys Who Have Considered Suicide When The Hue Gets Too Heavy,"* which sparked important conversations about mental health and well-being, allowing them to share coping strategies with each other.

EVIDENCE AND IMPACT

The WAMHS conference provided a platform for educators and mental health workers to hear from young people directly, with a standout performance from Haggerston School drama students and a poignant speech from a young person on the autism spectrum. This highlighted the importance of compassion-focused approaches in schooling.

EVIDENCE AND IMPACT

Hackney Education actively consulted with fathers and male carers to inform the development of Children and Family Hubs.



EVIDENCE AND IMPACT

In March 2025, the City of London Corporation completed its 10th independent Annual Survey. This involves individually contacting all children, parents and carers, children in care, and care leavers, who have received services from Children's Social Care and Early Help. A tailored survey of questions is asked to each person, dependant on the type of service they have accessed. The exercise ensures that an impartial view of service user experience is collated and demonstrates to children, parents and carers, children in care, and care leavers that their experiences matter, and services can and will adapt in response to their feedback.

This year there was a 51.2% completion rate. There remained consistently positive feedback about the work of Early Help and Children's Social Care services within the survey. Although it was noted by a small number of families that they would welcome more support around housing and managing /supporting additional needs of their children. 100% of children in care responded to the survey. All are happy with where they are living and gave positive feedback about support and accessibility of social workers. All children felt that they had safe people in their lives to speak to.

Themes of loss and isolation continue, not surprisingly, to prevail within the care leaver cohort, given the majority are former unaccompanied asylum-seeking children. However, this year callers had been provided with a range of support services to signpost young people too. Where young people described unhappiness with their home, this was in main due to wanting a permanent tenancy. There were strong positive feelings towards social work support seen.

EVIDENCE AND IMPACT

This case study explores the engagement strategies adopted by the City of London Corporatiopn's Education Welfare Manager, in supporting a secondary school student with significant health challenges. The student has been experiencing recurrent health issues, leading to chronic fatigue and significant absences from school. The Education Welfare Manager conducted a home visit to understand the young person's health challenges and gather detailed information from his family. A follow-up letter was sent to parent outlining what was discussed during the home visit and noted actions agreed during the visit. Consent forms were also agreed for the education welfare manager to make contact with health professionals to ensure transparent sharing of information and implementation of prompt and appropriate support. Regular communication was then maintained with the family. This included offering tuition during the summer holidays and exploring flexible schooling arrangements to accommodate the young person's health needs. To ensure the effective implementation of support, the education welfare manager worked closely with the young person's school, to ensure they were aware of his health challenges and could provide appropriate support, including the creation of an Individual Education Plan (IEP). Community resources were explored to ensure comprehensive support for the young person. The education welfare manager actively collaborated with health professionals to ensure a comprehensive understanding of the young person's medical condition and to coordinate support. Regular communication took place with the Head of Year and Safeguarding Lead on several occasions and has extended to the broader community, including liaising with external tutoring providers to arrange educational support for the young person. The education welfare manager has also explored support options from community organisations, such as Young Carers, to provide additional resources for the young person and his family. There is now a more comprehensive plan in place to support this young person as we move into the new academic year.

EVIDENCE AND IMPACT

Clinical Service 2024 Focus Groups: In 2024, the Hackney CFS Clinical Service engaged with children and families who had previously received support from the Surge team. The Surge team has since discontinued but previously offered support for young people presenting in mental health crises and those at risk of Tier 4 (specialised day and inpatient units) admission. Focus groups and telephone discussions were held to understand their experiences of seeking support for their child's mental health and what improvements could be made. The feedback has contributed to the ongoing informing and improving children and families services.

EVIDENCE AND IMPACT

Children's Rights Service SHOUT survey: In November 2024, Hackney CFS asked children and young people who are currently looked after or are care experienced, to tell us about their recent experience of receiving support from their Children's Rights Officers (CROs). An online, child-focused survey was used and 16 responses were received. The responses highlighted positive experiences with Children's Rights Officers (CROs), who are seen as supportive, accessible, and effective in helping young people understand their rights and have their voices heard. Responders appreciated the CRO's ability to listen, provide guidance, and ensure they felt supported during important processes. There were suggestions for improvement, such as quicker responses and better communication. The feedback emphasised the importance of CRO's building trusting relationships, creating a safe environment, and avoiding judgment.

EVIDENCE AND IMPACT

Special Guardian Support Group Questionnaire: Between January 2025 and February 2025 a questionnaire was sent to Hackney's Special Guardians mailing list to understand the challenges Special Guardian's face in their roles, areas of advice and support they may most benefit from and the structure and content of the regular Special Guardian Support Groups. 31 responses to the questionnaire were received, which is 23% of the total mailing list. Those who responded identified some of the main challenges they currently face include dealing with educational challenges for their child, finances, supporting the emotional wellbeing and mental health of their child and managing their child's behaviour. Responders also suggested improvements to the support, information and guidance they are offered. The survey results will be used to inform the support provided for special guardians going forward.

EVIDENCE AND IMPACT

Compliment about Hackney CFS from a parent or carer: *"I wanted to express how deeply appreciative I am of [Social Worker]'s support. [Social Worker]'s ability to understand and motivate [child] has made a lasting difference in their life"*

Compliment about Hackney CFS from a parent / carer: *"Thank you so much for your work with [Child], it has made a huge difference, and you have helped them through a very difficult time and they have come out confident and happy the other side"*

EVIDENCE AND IMPACT

The WAMHS conference provided a platform for educators and mental health workers to hear from young people directly, with a standout performance from Haggerston School drama students and a poignant speech from a young person on the autism spectrum. This highlighted the importance of compassion-focused approaches in schooling.

EVIDENCE AND IMPACT

Hackney Education actively consulted with fathers and male carers to inform the development of Children and Family Hubs.

EVIDENCE AND IMPACT

Working with local schools and their communities, the Met Police further developed the concept of Safer Corridors. This involved the Safer Neighbourhood Teams and schools working together to prevent children becoming victims of crime on their way home from school. The overall aim has been to provide 'safe routes' using crime data and feedback from children around where they feel less safe. Patrols are on foot and on pedal bikes whilst engaging with schoolchildren. Collaboration with one secondary school (Haggerston) resulted in a change in how detentions were issued (from after school to lunch time) to make it less likely children would become victims of crime on their way home.

EVIDENCE AND IMPACT

In 2024, Hackney Council and City and Hackney Safeguarding Children Partnership held a series of meetings with AFRUCA Safeguarding Children to discuss the over-representation of African and Caribbean families in the child protection system as a result of physical chastisement. The local authority was aware that parenting of children in most of these families is good and the incidents of physical chastisement relate more to parenting understanding of what is acceptable or not in terms of chastisement, as opposed to there being any underlying abusive intent. Hackney and AFRUCA agreed to collaborate to deliver a series of three safeguarding training events for faith leaders and workers in Black faith organisations so they can better understand the law and expectations surrounding physical chastisement and how to talk to parents about keeping their children safe. 65 participants from 30 churches attended three events facilitated by AFRUCA. The participants contained a mix of Pastors and leaders in the church. These were the right people who could go back and make a difference to safeguarding decisions in their organisations.

Performance Data

Whilst the CHSCP maintained two area-based datasets which captured a range of safeguarding metrics across the local partnership, with the loss of personnel, the increased use of AI and a focus on avoiding duplication, new arrangements are being introduced to collate and interpret multi-agency safeguarding data for 2025/26. These new arrangements will enhance the focus on any key data shifts, and importantly, what the data might be telling us about performance and the quality of practice.

Front-Line Intelligence

The CHSCP did not issue a staff survey in 2024/25 as planned, primarily because of capacity issues within the CHSCP team. The ongoing focus on the CHSCP's priority on the Health and Wellbeing of the workforce facilitated ongoing insight into the views of front-line practitioners, as did the engagement of some within the CHSCP's reviewing and auditing processes.

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 coordinating 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.

Focus on CSA and CSE

In March 2025, the Home Secretary wrote to Local Authority Chief Executives, outlining the Government's commitment to doing all it can to tackle the horrific crimes of child sexual abuse (CSA) and child sexual exploitation (CSE). As part of this letter, the Home Secretary expressed an interest in receiving an update on how local areas were prioritising their response child sexual abuse and exploitation, and the specific actions being taken to tackle this issue. The following sets out the basis of this response from the CHSCP Executive covering both the City of London and Hackney:

EVIDENCE AND IMPACT

The CHSCP has undertaken a wide range of actions and activities in both Hackney and the City of London to combat Child Sexual Abuse (CSA) and Child Sexual Exploitation (CSE). Our efforts are consistently guided by our "Safeguarding First" approach and our commitment to ensuring children are seen, heard, and helped. Our approach has been multifaceted, encompassing prevention, early intervention, disruption of offending, and victim support, as detailed in our annual reports for 2020/21, 2021/22, 2022/23, and 2023/24.

EVIDENCE AND IMPACT

Learning from Reviews: The CHSCP appropriately conducts Local Child Safeguarding Practice Reviews (LCSPRs) to learn lessons from serious child safeguarding cases and improve multi-agency working. In terms of CSA, the recent CSPR on Case A examined how local agencies managed and mitigated risks posed by a known child sex offender, identifying a lack of robust professional curiosity and insufficient focus on the child's paramountcy. Recommendations from this review aim to improve referrals to children's social care, strengthen guidance on risk management of offenders, and enhance information sharing with key agencies. One recommendation arising from this review links to Multi-Agency Public Protection Arrangements (MAPPA) and we have been engaged with the Child Safeguarding Practice Review Panel on how best to progress improvements at a national level. Another relevant LCSPR (Child W) has recently been finalised. A defined CSA task group has been set up to collate and drive the recommendations arising from this review, Case A, and the national panel's review on CSA.

EVIDENCE AND IMPACT

Auditing and Quality Assurance: The CHSCP implements multi-agency case auditing programmes focusing on specific areas such as intra-familial CSA. these audits lead to outcome-focused action plans and inform briefings for frontline professionals.

EVIDENCE AND IMPACT

Staff Training and Development: The CHSCP provides a comprehensive training programme covering various safeguarding topics, including child sexual abuse, exploitation, and online safety. Training content incorporates learning from local and national case reviews. For instance, specialist training has been commissioned to increase understanding of child sex offenders, all City social workers are now ABE trained and there is ongoing focus on broadening the cohort of trained social workers in Hackney. The CHSCP routinely seeks assurance and evidence from healthcare providers and other agencies that CSE/CSA is included in mandatory training.

EVIDENCE, IMPROVEMENT AND IMPACT

The City of London - Identification and Response:

The City of London experiences a low number of cases, with most contacts related to non-residents. Relevant crimes recorded by City Police included rape, sexual activity, and possession of indecent images, as well as grooming via the internet/social media. The City Multi-Agency Sexual Exploitation (MASE) panel was changed to the Multi-Agency Child Exploitation (MACE) panel to encompass all forms of child exploitation and abuse that adolescents are at increased risk of.

The City of London's location as a major transport hub is significant for intelligence sharing among partner agencies. The City maintains an "it could happen here" stance despite relatively lower risks compared to neighbouring Local Authorities.

The City Police lead on all children missing from home or care, with a coordinated response involving the City Children and Families team. Numbers of missing children in the City of London are very low. Coram Voice conducts independent return home interviews within 72 hours, with therapeutic support offered based on outcomes to address risk-taking behaviour. These interviews are reviewed by the partnership to inform strategy and service delivery. Workers use a range of tools, which they regularly update when children's circumstances change, including risk of exploitation and going missing.

The City of London's MACE panel uses quarterly data and intelligence to understand and identify risk indicators related to all forms of child exploitation. The City of London Police has restructured its public protection department to have specialist officers available out of office hours and seven days a week.

"Operation Makesafe" is ongoing and involves plainclothes police officers attempting to book hotel rooms with a child not related to them, providing feedback and advice to hotels on identifying and disrupting CSAE.

"Operation Reframe" targets the night-time economy to create safer environments for vulnerable people, including test purchases at licensed premises to identify and address alcohol sales to children.

EVIDENCE, IMPROVEMENT AND IMPACT

Hackney - Identification and Response:

In Hackney, children at high risk of extra-familial harm benefit from effective interventions. Professionals work across service areas and through multi-agency panels to robustly explore risks and vulnerabilities for children. Actions are identified to help reduce risk, harm and offending, and to increase children's safety. Children are seen within the context of their own needs as well as within their family, community, and peers. Progress is evident for some children; risks have reduced through successful interventions and the trusting relationships built with key practitioners. If risks increase, children's cases are appropriately escalated through child protection processes to coordinate the multi-agency response.

Analytical research has highlighted three broad CSE profiles: peer-on-peer abuse (sexual offences/exploitation in a group setting), adult perpetrator exploitation (young person believing they are in a relationship with an adult through vulnerable friends or online contact), and exploitation via social media (inciting explicit image sharing).

In Hackney, contacts identifying Child Sexual Exploitation as a potential concern were received for 37 children during 2023/24. There were 1,301 missing episodes reported over the same time period, involving 265 children. The most prominent reason for children going missing was "difficulties at home or school," with overcrowding also noted. Mental health, emotional wellbeing, and learning needs were also precipitating factors. Contacts for 167 children identified Criminal Exploitation (CE) as a potential concern, and 145 children had statutory social work assessments where CE was a factor.

Most CE referrals related to male children from Black and Global Majority backgrounds. Contacts for 185 children identified Serious Youth Violence and Weapons as a potential concern.

The Youth Justice Service reported a 19% decrease in first-time entrants to the youth justice system in 2022/23, with 91% of triaged young people successfully diverted. An Extra-Familial Risk Panel continues to oversee and plan for cases where young people are at risk of harmful behaviours outside the home, with strong multi-agency attendance from Police, Education, Health, Youth Offending Team, Young Hackney, and the Community Gangs Team.

The Metropolitan Police Service's handling of sexual and criminal exploitation of children has improved. The force's children's strategy now sets out the commissioner's ambition to adopt a 'child first' approach. This aims to make sure officers and staff recognise that children are different from adults and should be treated differently because they have different needs and vulnerabilities.

Continued overleaf

EVIDENCE, IMPROVEMENT AND IMPACT continued

Through a renewed focus on child exploitation, its links to missing children and the language the force's officers and staff use, the force has made positive progress. The changes the force has implemented are also now providing better outcomes for children in London.

The Metropolitan Police Service's Safer Schools and Youth Engagement Teams regularly deliver presentations on various safeguarding issues, including youth-produced sexual imagery (YPSI), exploitation, and gangs.

In terms of managing offenders, Probation and Jigsaw staff in Hackney are co-located which has been reported to assist in better collaboration locally. There is now greater emphasis on joint working, home visits, risk assessment, and information sharing.

Children's social care in Hackney has taken significant steps to strengthen its practice in response to child sexual abuse. Alongside identifying dedicated practice leads to develop expertise and be available for consultation, practitioners have access to much clearer guidance and there are defined processes in place such as the following:

- To ensure leadership focus, service managers are informed about any disclosures of child sexual abuse.
- Multi-agency strategy meetings under Section 47 of the Children Act 1989 are convened to discuss risk, develop safety plans, and determine the approach to investigation. There is an expectation that a safety plan is coproduced with the protective care giver, recorded on the case management system, and shared with the family and professionals.
- Importantly, there is defined guidance covering how to issue instructions for specialist risk assessments. This includes the following narrative about how Jigsaw risk assessments should be considered: 'Risk judgement offered by the Jigsaw team engaged with convicted sexual offenders - This judgement of risk is given based on a number of factors present or absent at a specific point in time. This risk judgement should always be reviewed in light of changing context (e.g., living circumstances for the alleged perpetrator), which could cause the assessed risk level to either increase or decrease. We should not base our decisions about child safety on this risk judgement alone.'
- Revised guidance is also much more explicit about the need for direct work with children and how to engage them and protective carers. Within this guidance, there are clear examples about the practical work that can be undertaken.
- Defined pathways are in place at Homerton Hospital covering the management of suspected CSA. Routine awareness raising continues and best practice is promoted via the Centre of Expertise on CSA.

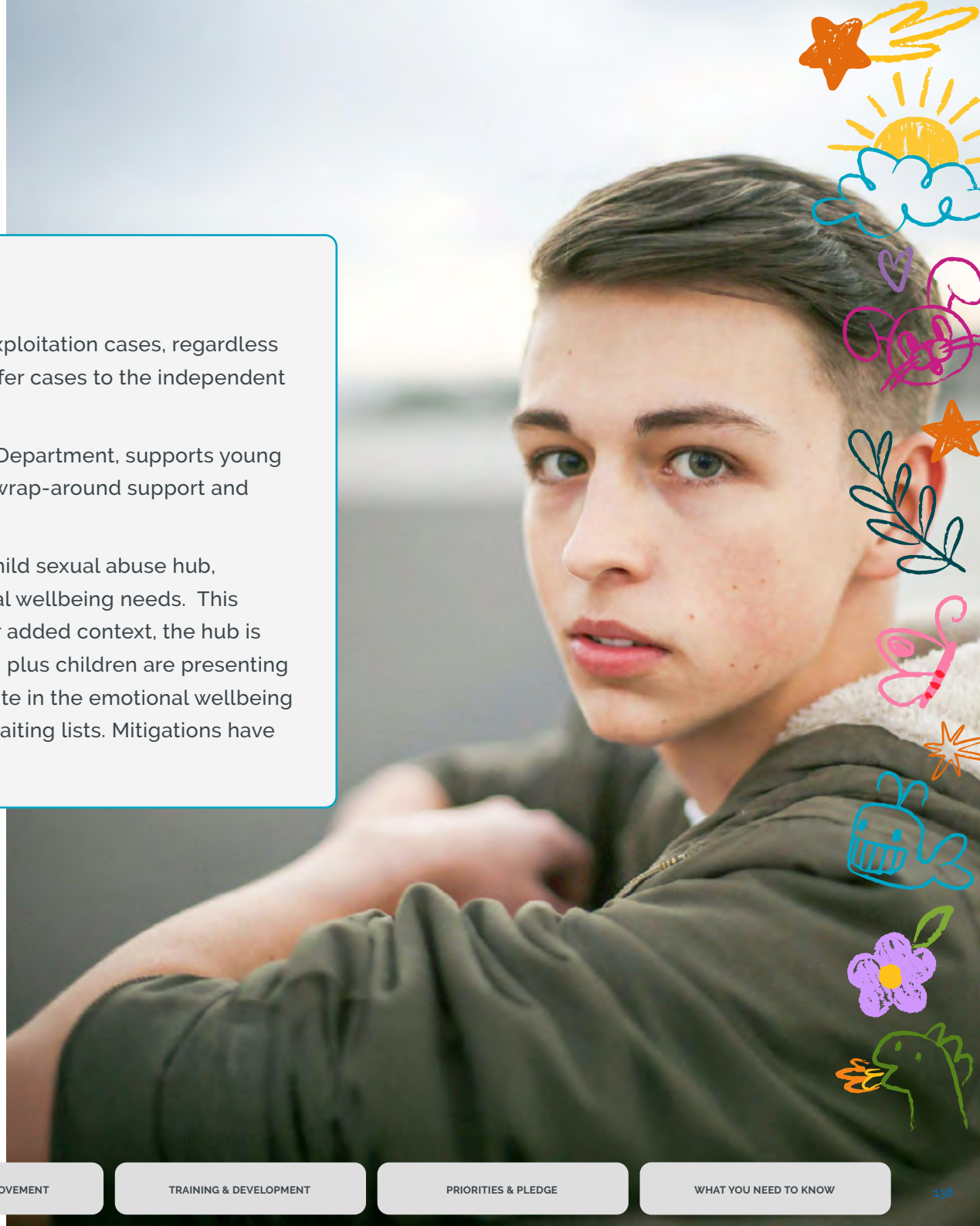
EVIDENCE AND IMPACT

Support for Victims and Vulnerable Children:

The expansion of the right to review for all child sexual abuse and exploitation cases, regardless of when they took place, is being promoted to ensure victims can refer cases to the independent Child Sexual Abuse Review Panel.

Redthread, a charity embedded in Homerton Hospital's Emergency Department, supports young people affected by or at risk of violence and exploitation, providing wrap-around support and diverting them from offending.

The Sunrise (previously NEL CSA Hub) at Royal London provides a child sexual abuse hub, collaborating with Barnardo's to address both medical and emotional wellbeing needs. This setting was visited by the Children's Commissioner in April 2025. For added context, the hub is facing increasing demands as the number of referrals are increasing plus children are presenting with increasing complexity and vulnerability. The impact is most acute in the emotional wellbeing and support service with pressures arising in terms of volume and waiting lists. Mitigations have been implemented, but the waiting list is now 12 months.



Training & Development

Summary

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.

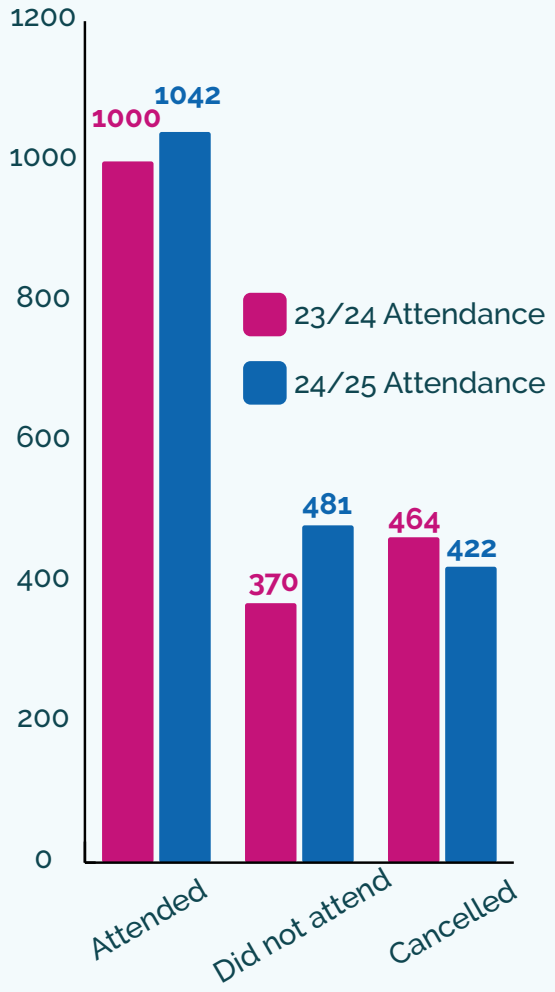
EVIDENCE

- 77 training sessions were held in 2024/25
  (An increase from 60 in 2023/24, 56 in 2022/23 and 47 in 2021/22).
- 43 safeguarding topics were covered.
- 17 new courses were introduced to the programme
- Most courses continued to be delivered virtually, with two face-to-face sessions held.

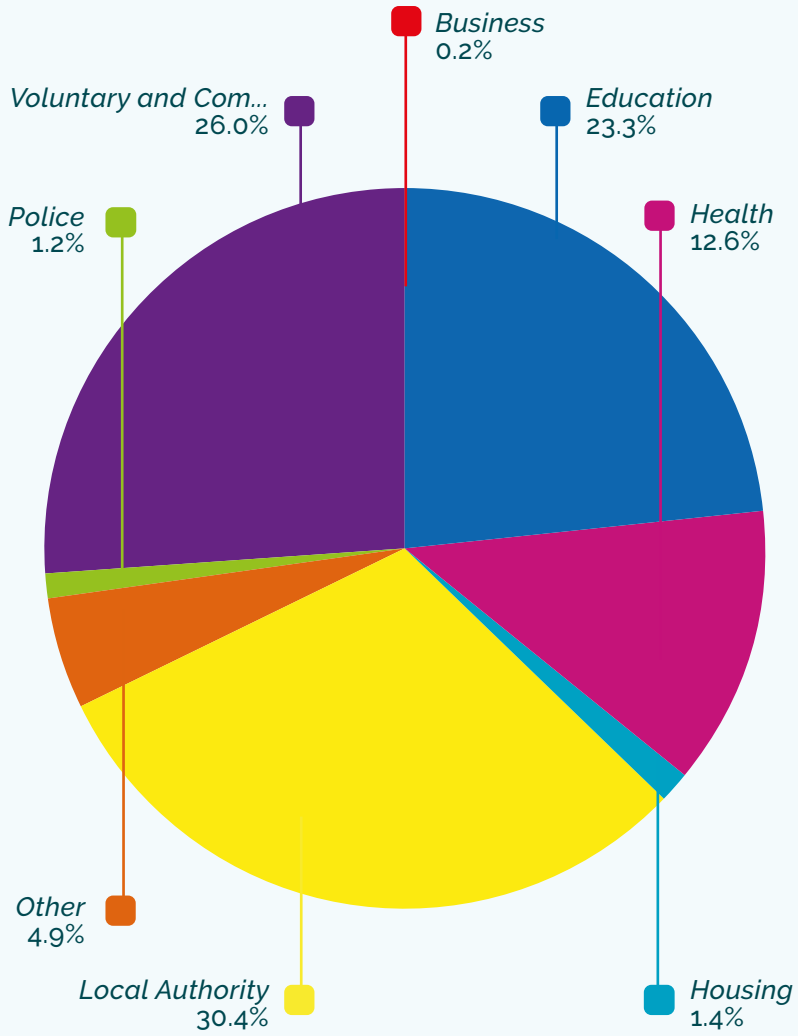
EVIDENCE

- Of the 1945 booked places (1834 in 2023/24), 1042 practitioners attended (and increase of 4% from 2023/24). 422 cancelled their training booking (a decrease of 9.1% from 2023/24). 481 did not attend the course (an increase of 30% from 2023/24).
- 67% of attended bookings were by practitioners working in Hackney, 16% in the City of London, and 17% by those working across both areas.

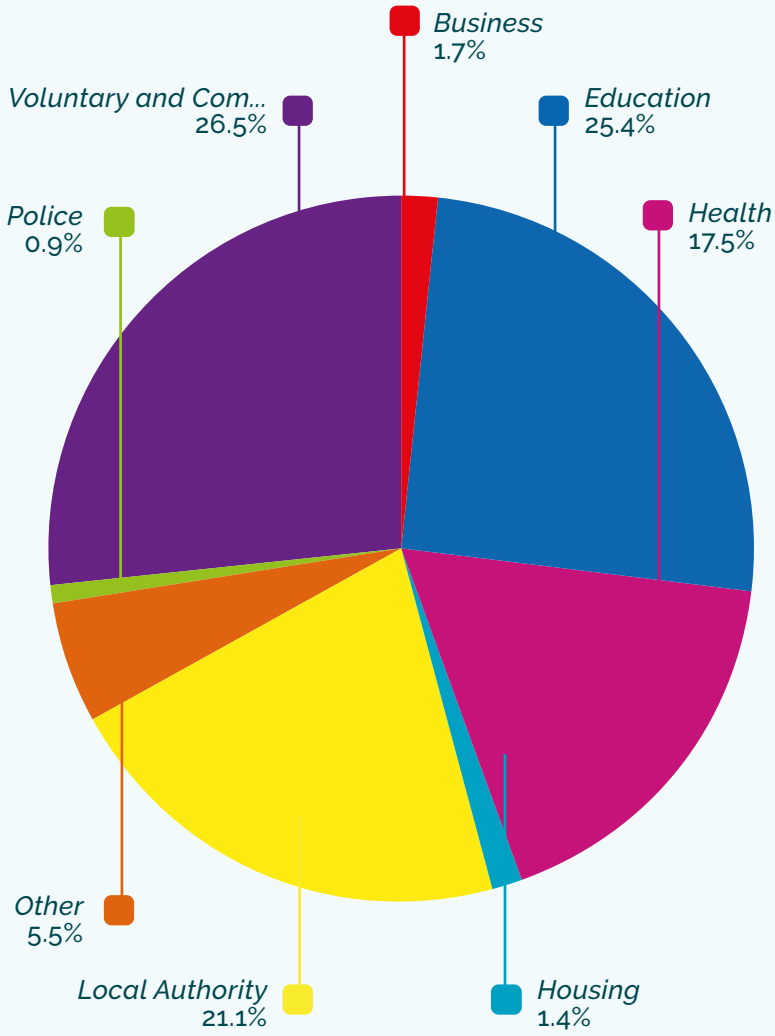
Attendance Status 2023/24 vs 2024/25



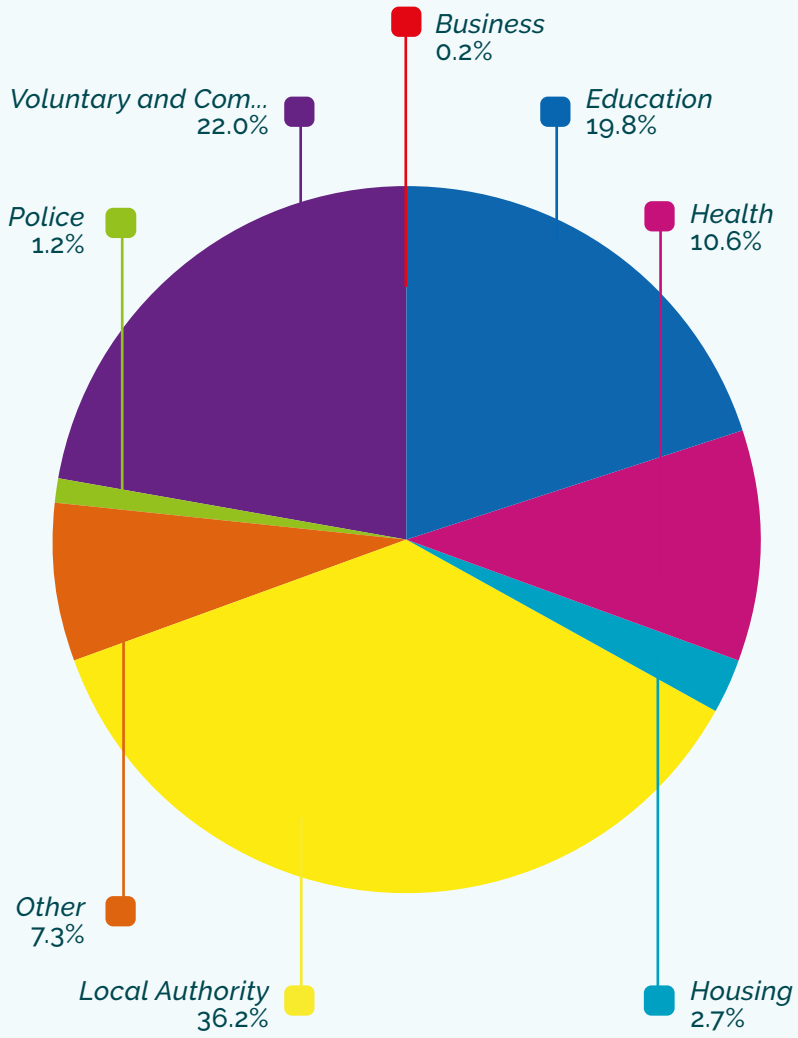
Attendance by Sector



Cancellations by Sector



Non-Attendance by Sector



EVIDENCE

In August 2025, the ISCC wrote to all partner agencies about the increase 'non-attendance' numbers.

In the current financial climate, we are all facing significant budgetary pressures. The costs associated with these no-shows are no longer sustainable. We rely on the goodwill of our knowledgeable colleagues to lead these sessions, and our budget, which supplements external training, is being wasted. Ultimately, this trend negatively impacts our ability to offer places to delegates on waiting lists, directly hindering our collective mission to provide high-quality training and support across the partnership.

We ask for your support in reinforcing the importance of this issue with your staff. Please remind them of their responsibility to prioritise and attend all pre-booked training. If a delegate cannot attend, they must follow the established cancellation process to free up the place for someone else.

If this trend of non-attendance continues, we will have no choice but to implement financial penalties to offset the wasted resources. We value your partnership and your commitment to ensuring our staff have the skills and knowledge they need to succeed. Your cooperation in addressing this matter is greatly appreciated.

EVIDENCE

Course Title	Delegates Trained 24-25
An Introduction to Child Sexual Abuse (CSA) in the Context of Exploitation	8
An Introduction to Female Genital Mutilation (FGM)	2
An Introduction to Intra-Familial Child Sexual Abuse	6
Child Criminal Exploitation and County Lines	34
Child Protection and Safeguarding Training for Faith Leaders	65
Child Sexual Abuse Education	11
Children's Wellbeing & Mental Health	28
Cultural Awareness - Gypsy Roma Traveller Cultural Competency Training	21
Cultural Awareness - Working with the Orthodox Jewish Community	49
Designated Safeguarding Lead' courses (Level 3)	180
Early Help Pathway, Request for Support Form and Assessment	12
Hear my Voice: Obtaining the Views and Opinions of Children with Communication Difficulties	33
How to Engage and Work with Fathers and other Male Caregivers	17
iCAN Dads: Working with Primary Male Caregivers	1
Identifying and Exploring Child & Adolescent to Parent Violence & Abuse	18
Impact of Neglect and Emotional Abuse on the Development of Children and Young People	30
Improving Professional Participation in Child Protection Conferences	11
LADO: Allegations Against Staff and Volunteers	7
LADO: Allegations against Staff and Volunteers Training for Faith Group Leaders	1
LADO: Completing Employment-Based Risk Assessments	10
LADO: Completing Internal Employment Based Investigations	14
Making Sense of Autism	26
Modern Day Slavery/Trafficking	7

Continued overleaf.

EVIDENCE CONTINUED

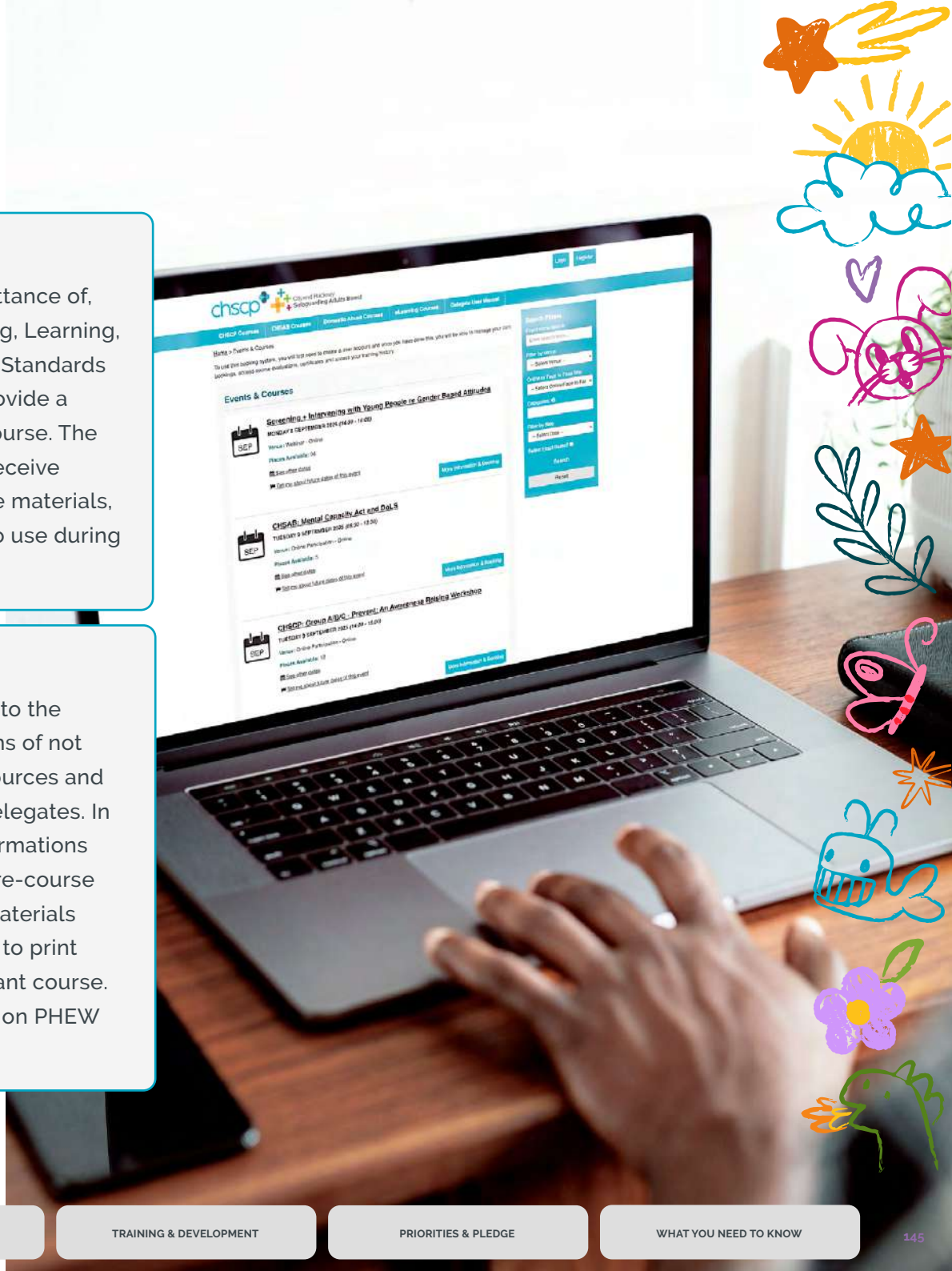
Course Title	Delegates Trained 24-25
Non-Recent Child Sexual Abuse	14
Oral Health Care	5
Parental Mental Illness: Impact on Parents, Parenting Capacity and Children's Development	22
Parenting Together: Improving the Relationship and Communication of Co-Parents	6
Prevent Duty Awareness	53
Private Fostering Workshop	4
Protecting Children and Vulnerable Adults from Abuse Linked to Faith or Belief	8
Recognising the Difference between Domestic Abuse and Parental Conflict	13
Relationship Solutions - The Relationship Toolkit for Working with Parental Conflict	15
Safe Space: Structuring and Conducting Sessions with Families to Create Positive Interactions whilst Tackling CAPVA	7
Safeguarding Children Basic Awareness courses (Level 1)	113
Safeguarding Children with Disabilities	10
Safeguarding in a Digital World	28
Safer Recruitment	9
Safer Sleep	24
The Child Death Overview Process	
Understanding Adultification Bias	47
Understanding Adults Who Sexually Abuse Children (Foundation Level)	7
Understanding Adults Who Sexually Abuse Children (Intermediate Level)	25
Understanding Adverse Childhood Experiences (ACEs), Trauma, and Trauma Informed Practice	37
Working with Cultural & Economic Diversity	4
TOTAL	1042

EVIDENCE

To curb inconsistencies between courses, particularly relating to the admittance of, and recognition of attendance status for late attendees, the CHSCP Training, Learning, and Development Subgroup approved two versions of Course Attendance Standards for Delegates covering virtual and face-to-face training. The standards provide a comprehensive list of instructions covering before, during, and after the course. The content covers pre-evaluation completion, when and how delegates will receive joining instructions, how to cancel course registration, downloading course materials, the strict registration cut-off point, expectations related to visual and audio use during the course, and the evaluation schedule post course.

EVIDENCE

The PHEW learning management system continues to be a great addition to the training element of the CHSCP. It has helped to reduce admin time in terms of not having to download registration data and evaluation data from multiple sources and the training coordinator not having to produce individual certificates for delegates. In addition, the system sends calendar invites for each course, booking confirmations and reminder emails to delegates. Delegates are now able to download pre-course materials up to one week prior to their training session, and post course materials following their attendance being recorded online. Delegates are also able to print their own certificates after completion of the evaluation form for the relevant course. During 2024/25, the CHSCP's Training Coordinator utilised the information on PHEW to create 41 separate evaluation reports.



Evaluation

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues to monitor and evaluate the effectiveness of its core training programme. The evaluation schedule involves post-course feedback and follow-up engagement with delegates and their line managers, seeking evidence of how training has influenced practice. This has enabled the CHSCP to gain important insight into the difference its training programme is making towards improving outcomes for children and young people.

EVIDENCE

97.6% of delegates stated that the trainers' facilitation skills, teaching style and knowledge were GOOD (10.2%) VERY GOOD (37.5%) or EXCELLENT (49.9%). This feedback is a testament to the skill and expertise of our internal & commissioned trainers.

IMPACT

97.7% stated what they had learned would help them safeguard children & young people more effectively.

95.6% said the course met their expectations.

IMPACT

It's a lot to pack into one day and is full on and exhausting. It's quite hard to take in all the data. However, there was no part of the day I found not useful.
An Introduction to Intra-Familial Child Sexual Abuse - Post Course Evaluation.

Being able to discuss the case study with other people and hearing others' ideas really helped me to consider things that I may not have thought about before.
LADO: Completing Internal Employment-Based Investigations, Post Course Evaluation.

It was quite rushed at the end when arguably covering the most important part.
Cultural Awareness: Working with the Orthodox Jewish Community - Post Course Evaluation.

Continued overleaf

IMPACT Continued

Training was hugely informative. There was plenty of time for discussion with others, enabling a multidisciplinary approach to analysing this bias.

Marcia was very open to questions and perspectives being shared which fostered a positive environment to learn in.
Understanding Adultification Bias, Post Course Evaluation.

[It was most useful] learning about real life situations including reviews and what can be learnt from them to improve the chance of a better outcome.
Safeguarding Children: Basic Awareness - Post Course Evaluation.

I have used some of the communication skills discussed in the training which has allowed me to capture the voice of non-verbal young children more effectively.
Designated Safeguarding Leads, Level 2 Evaluation.

I have explained to colleagues in a clinical supervision situation that what they were describing when discussing a family situation was not domestic abuse, but a conflict situation that they could help the parents to resolve.
Recognising the Difference between Domestic Abuse and Parental Conflict, Level 2 Evaluation.

The knowledge I received during the training has enabled me to become culturally sensitive and this has had a positive impact on my health assessment of children and young people.
Gypsy Roma Traveller Cultural Competency Training - Basic Awareness, Level 2 Evaluation.

[The employee] has not been directly involved in safeguarding issues and has not come across a situation where she has had to raise a safeguard in the last 6 months. However, we have discussed the training in supervision and the big takeaway from the training was that supporting the individual's communication needs is not classified as 'leading questions'.
Hear my Voice: Obtaining the Views and Opinions of Children with Communication Difficulties, Level 2 Evaluation.

[The staff member is] more confident to deal with issues as they arise and able and willing to engage in discussions at a management level.
Designated Safeguarding Leads, Line Manager Feedback.

[The member of staff now] understands drug related issues that affect young people.
Child Criminal Exploitation and County Lines, Line Manager Feedback.

No differences noted in practice. Staff members noted that they did not think the content of the training was useful and that the delivery was a little disorganised.
Working with Economic and Cultural Diversity to Safeguard Children, Line Manager Feedback.

Priorities & Pledge

CHSCP Priorities 2024/25

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

Active Anti-Racist Practice

Outcome
The partnership's approach to safeguarding children is characterised by active anti-racism and aligns with the CHSCP's Anti-Racist Charter. Practice that disproportionately and negatively impacts on Black and Global Majority children (and their outcomes) is identified and reduced. Children and their families are confident in challenging their experiences of racism, have mechanisms in place to escalate their concerns and tell us that they can see change. Practitioners are confident in challenging racism, and this happens.

PRIORITY 3

The Voice of Children

Outcome
Multi-agency safeguarding practice reflects the lived experience of children. The voices of children are central to all aspects of the child's journey and are used to influence service design, develop practice and improve outcomes.

PRIORITY 4

Maintaining and Building on the Foundations of Good Practice

NEW

Outcome

Multi-agency safeguarding practice demonstrates a strong foundation, continuous improvement and alignment with the national standards for child protection. Children and families are effectively supported by early, robust, timely and coordinated multi-agency help and protection.

PRIORITY 5

Strategic Vulnerabilities & Pathways to Harm

NEW

Outcome

The CHSCP identifies and develops action in response to identified strategic vulnerabilities and the pathways to harm facing children. For 2025/26, local priorities centre on Child Sexual Abuse, Safeguarding Adolescents, Neglect and Unregistered Educational Settings.

PRIORITY 6

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.

Our Pledge

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 – organisational change, 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.

ACTIVE ANTI-RACIST PRACTICE

Through our collective leadership, we will model our values and promote a way of working that puts active anti-racism front and centre. This will be seen in the strategies we develop, the decisions we take and the people we employ. Critically, active anti-racist practice will be evidenced in the behaviours of our staff and volunteers. Through a relentless focus on improvement and challenge, Black and Global Majority children and families will see, hear and feel the difference when engaged by those responsible for their help and protection.

THE VOICE OF CHILDREN

We will support and enable a culture of working that routinely seeks out and reflects the voices of children. The lived experience of local children 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 their families.

NEW

MAINTAINING AND BUILDING ON THE FOUNDATIONS OF GOOD PRACTICE

The CHSCP recognises that good practice is built upon solid foundations, and we are committed to maintaining and continuously building upon these. We will maintain focus on ensuring these fundamental aspects are embedded in our work, covering the journey of the child through the safeguarding system. This includes our approaches to family help, child protection, looked after children, and care leavers.

NEW

STRATEGIC VULNERABILITIES & PATHWAYS TO HARM

We will proactively respond to local strategic vulnerabilities and identified pathways to harm through robust and focused multi-agency arrangements. We will commit to developing our understanding of these issues and work together to implement solutions that directly support practice, improve outcomes and help tackle the root causes of harm to children.

THE APPPETITE 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 Safeguarding Children Commissioner, the right to 'roam', the right to ask difficult questions and the right respectfully challenge. Whenever required, safeguarding partners, relevant agencies and named organisations will provide whatever information they can to address a relevant enquiry or concern.

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 you to help us find the best way to do this.
- **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 from getting worse. Don't be afraid to ask for help.
- It's important to tell us what works for you and what doesn't so that professionals can help you in the best way possible.
- 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.**

Practitioners

- Make sure 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 Politicians

- 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.
- Deputy Mayor Anntoinette Bramble (Hackney) and Ruby Sayed (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.

Leaders

- 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.
- Make sure your DSLs and Deputy DSLs have access to good quality supervision, support and training.

NHS
North East London

Integrated Commissioning Boards

- The ICB has a key role in scrutinising the governance and planning across a range of health 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.**

chscp

SEEN | HEARD | HELPED

www.chscp.org.uk

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