
# city & hackney safeguarding children partnership

# ANNUAL REPORT 2022/23

# Foreword

Without a healthy workforce across our partnership, we will be unable to provide the collective support that our community requires. That is why we continued to focus on their health, wellbeing, and stability over the reporting period of this annual report. Practitioners from all agencies are operating in difficult times defined by increases in the cost of living, greater need, complex cases, growing workloads and shrinking budgets. Whilst this has resulted in pressure, our staff survey indicates that many staff still feel supported within their organisations. We welcome this but recognise there are limits, alongside the need for ongoing oversight in this area.

Whilst many organisations had already begun work to address racism, the activity of the partnership following the Child Q case has been more firmly focused and we are determined to drive change. Developing anti-racist strategies cannot, in my opinion, be limited to policy papers and grand statements. All our young people must see and feel a change. Anyone can say they are anti-racist, but it is actions that make the difference. Going forward, we need policies informing practice, actual challenge and clear outcomes that are measurable. Whilst we have seen some promising initiatives, it is too early to say there has been substantial impact. In this regard, I look to the statutory partners to lead by example. Their leadership is key and agency leads must both recognise and contribute to the work that will drive change.

Whether as part of helping develop strategy, understanding performance, or improving practice, the partnership has demonstrated its commitment to hearing the voices of children, young people, their families and the community. Whilst there are a variety of ways we do this, we have learnt that reaching out and listening to authentic voices in places and spaces where people feel safe and able to share, is key. On that note, I'd like to put on record my gratitude to all those young people and community members who spoke with me as part of the Child Q review and update report. I want to reassure them all that this was the beginning of a process not the end. I will re-engage them in the coming months to ensure that they remain involved in the work that guarantees our commitments are delivered.

Whilst this annual report covers a range of issues reflecting the good work done by many of our partners in health, social care, the voluntary and criminal justice sectors, we recognise that there is room for improvement. We therefore remain committed to a continued focus on getting the basics right and getting them right in the context of the City of London and Hackney. This has been reflected through the themes overseen by the CHSCP Executive, the Boards, and the various subgroups in place across our partnership. The report sets out the detail of the activity undertaken in these areas, including our self-assessment programme, staff survey, auditing, and training delivery.

We are fundamentally committed to a safeguarding first approach and to this end our appetite to learn remains strong. Representatives from each partnership agency and organisation continue to support our core sub groups. We are also supported by a determined partnership team, and I want to thank the Senior Professional Advisor, the CHSCP's Business & Performance Manager, Training Coordinator and Partnership Coordinator for all the work they have done and continue to do.

Finally, at the time of writing, the government has just released the revised statutory guidance, Working Together 2023. We will do everything we can to ensure that our response to this strengthens safeguarding wherever possible, whilst retaining the critical level of independent insight and oversight that ensures we are all doing what is right and what is best for our children.

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

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# About the Annual Report

# About the Annual Report

The City & Hackney Safeguarding Children Partnership annual report for 2022/23 sets out examples of the evidence, impact, assurance and learning 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.
- The context for safeguarding children in the City of London, highlighting the progress made by the City of London partnership.
- The context for safeguarding children in the London Borough of Hackney, highlighting the progress made by the Hackney partnership.
- The lessons that the CHSCP has identified through its Learning & Improvement Framework, the key messages for practice and the actions taken to improve child safeguarding and welfare as a result of this activity.
- The range and impact of the multi-agency safeguarding training delivered by the CHSCP.
- The CHSCP's priorities going forward and the pledge of safeguarding partners.

In line with statutory requirements, the CHSCP annual report 2022/23 has been sent to the Child Safeguarding Practice Review Panel and Foundations, the What Works Centre for Children & Families.

IMPACT EVIDENCE ASSURANCE LEARNING

# The CHSCP

# Summary

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

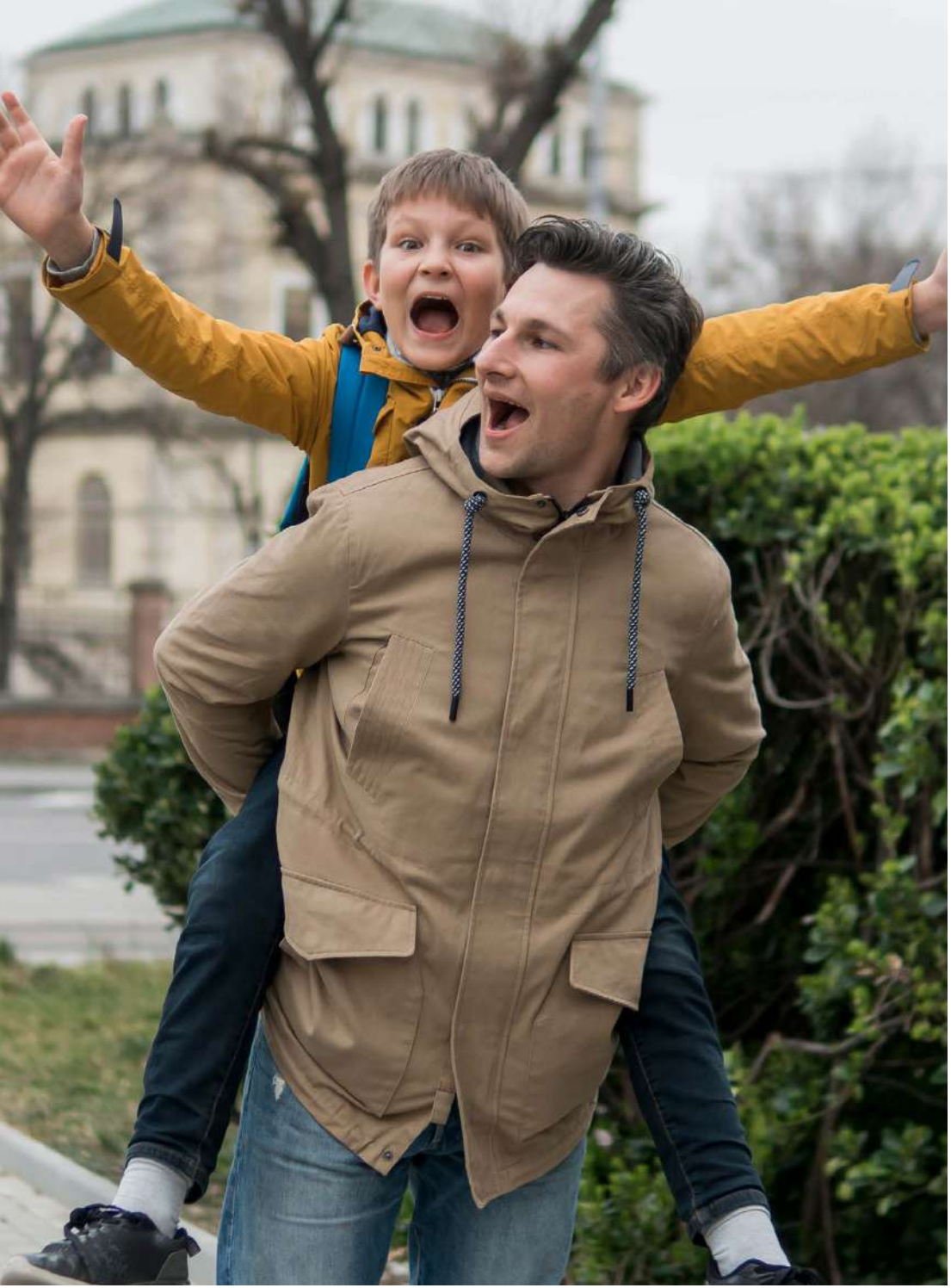
# Purpose

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

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

# Vision

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



# Principles

As leaders across a range of organisations, the commitment of the CHSCP is to work together to make the lives of children safer by protecting them from harm; preventing impairment to their health and 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 offline and online).*
- **Heard;** *by professionals taking time to listen to what children and young people are saying - putting themselves in their shoes and thinking about what their lives might truly be like.*
- **Helped;** *by professionals remaining curious and by implementing timely, effective and imaginative solutions that help make children and young people safer.*

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

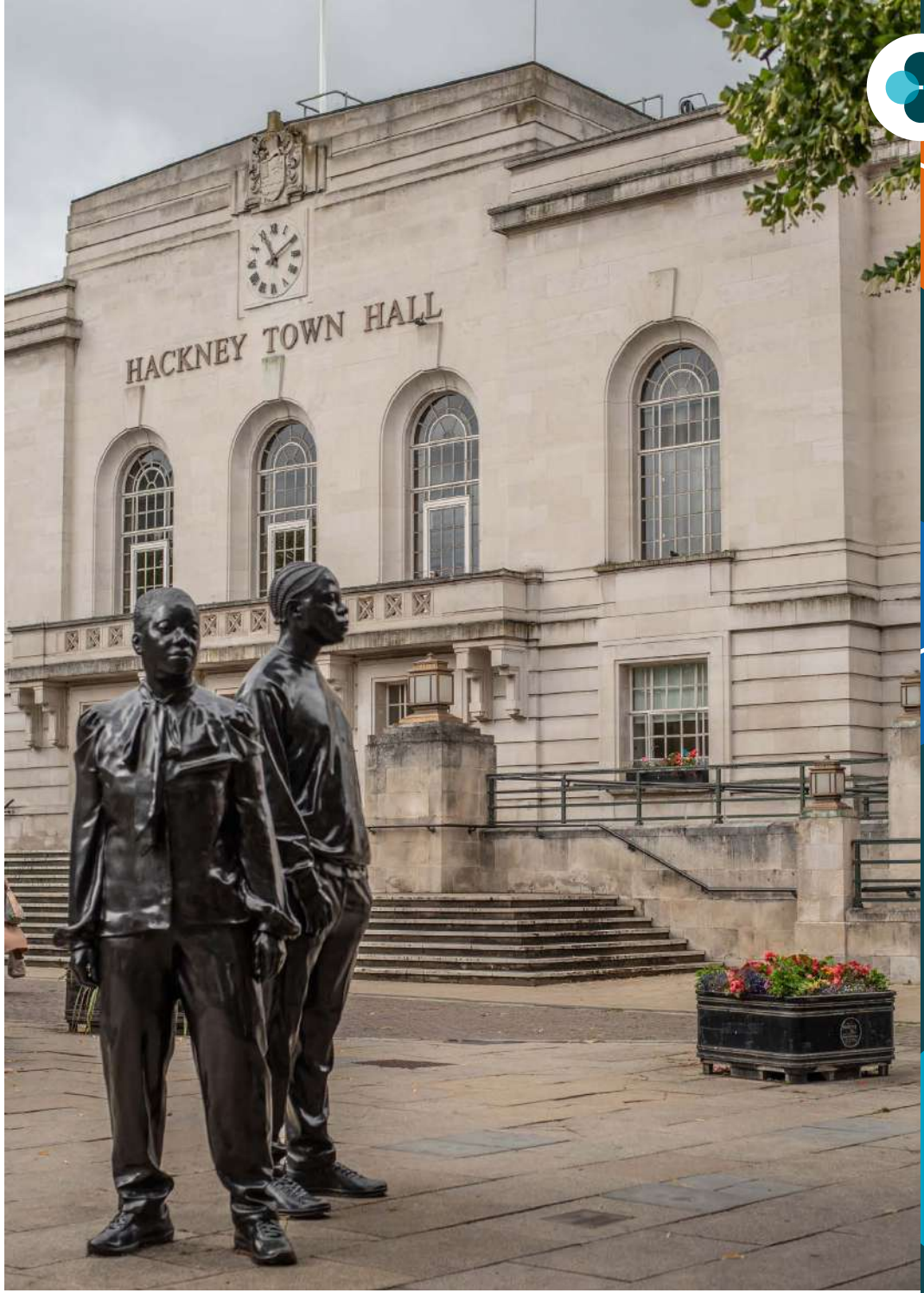
- **Safeguarding is everyone's responsibility.** As a partnership, we will champion the most vulnerable and maintain a single child-centred culture.
- **Context is key.** Capitalising on the unique opportunities presented by a dual-borough partnership, we will have an unswerving focus on both intra-familial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

# Key Roles and Relationships

## SAFEGUARDING PARTNERS

The safeguarding partners agree on ways to coordinate safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning. All safeguarding partners retain an equal and joint responsibility for local safeguarding arrangements. In situations that require a single point of leadership, safeguarding partners will decide which partner will take the lead on relevant issues that arise. The safeguarding partners in the City of London and the London Borough of Hackney are Hackney Council, The City of London Corporation, NHS North East London (NHS NEL), The Metropolitan Police Service (MPS) and The City of London Police. The lead representatives of the safeguarding partners during 2022/23 were:

- **Mark Carroll**, Chief Executive of Hackney Council
- **John Barradell**, Town Clerk of the City of London Corporation (to December 2022) / **Ian Thomas CBE**, Town Clerk of the City of London Corporation (from February 2023)
- **Zina Etheridge**, Accountable Officer of the City & Hackney CCG
- **Marcus Barnett**, Commander of the MPS Central East BCU (to July 2022) / **Mike Hamer**, Interim Commander (from August to December 2022) / **James Conway**, Commander of the MPS Central East BCU (from January 2023)
- **Angela Mclaren**, Commissioner, City of London Police



## RELEVANT AGENCIES

Safeguarding partners are obliged to set out which agencies are required to work as part of the CHSCP's arrangements to safeguard and promote the welfare of local children. These agencies are referred to as relevant agencies and have a statutory duty to cooperate with the CHSCP's published arrangements. A defined number of relevant agencies 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 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

## NAMED ORGANISATIONS

Safeguarding partners can also include any local or national organisation or agency in their arrangements regardless of whether they are named relevant agencies. Whilst not under the same statutory duty, there remains an expectation of compliance, with legal powers existing 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 PROFESSIONALS

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

## THE INDEPENDENT SAFEGUARDING CHILDREN COMMISSIONER

Jim Gamble QPM is the Independent Safeguarding Children Commissioner (ISCC) of the CHSCP. This role is appointed by safeguarding partners and given authority to coordinate independent scrutiny of the local child safeguarding arrangements. The ISCC is fundamentally independent and has delegated authority from safeguarding partners to instigate Local Child Safeguarding Practice Reviews. The ISCC has significant experience of operating at a senior level in the strategic coordination of multi-agency services to safeguard and promote the welfare of children.

### ASSURANCE

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

### ASSURANCE

The outcome of an internal audit conducted by Hackney Council in June 2022 found that the Independent Safeguarding Children Commissioner, with the focused support of the CHSCP's Senior Professional Advisor and the partnership team, enhanced the effectiveness of risk management controls and governance arrangements which were pivotal in the CHSCP's operational success.

## THE CHSCP EXECUTIVE

CHSCP Executive members are senior officers that can speak with authority for the safeguarding partner they represent. They can hold their organisation to account, take decisions and commit them on policy, resourcing and practice matters. The Executive is chaired by the ISCC and during 2022/23, comprised the following:

- **Jacquie Burke**, The Group Director of Children & Education
- **Andrew Carter**, The Director of Children and Community Services (The City of London Corporation) - to July 2022 / Clare Chamberlain, Interim Director of Children and Community Services (to March 2023)
- **Amy Wilkinson**, Integrated Commissioning Director NHS NEL ICB (to October 2022) / Diane Jones, Chief Nursing Officer NHS North East London ICB (from January 2023)
- **Marcus Barnett**, The Commander of the MPS Central East BCU (to July 2022) / Mike Hamer, Interim Commander of the MPS Central East BCU (from August - to December 2022) / James Conway, The Commander of the MPS Central East BCU (from January 2023)
- **Umer Khan**, T/Commander, City of London Police
- **Annie Gammon**, Director of Hackney Education (Hackney Council) to August 2022 / Paul Senior Director of Hackney Education (from September 2022)

### IMPACT

The CHSCP Executive had already extended its membership to include Hackney Council's Director of Education. To further strengthen its engagement with the education sector, Mark Emmerson, the Chief Executive Officer of the City of London Academies Trust, is also now a formal member of the group.

### CHALLENGE

As part of a recent consultation on the statutory guidance, Working Together, the CHSCP Executive submitted a collective response to the Department for Education. This confirmed our local position that 'Education' should be made the fourth statutory safeguarding partner. The view of the Executive is that this sends a clear message about the leadership role that schools and colleges have in safeguarding and promoting the welfare of children and the need for them to be part of the leadership arrangements in local areas. This needs to be beyond their status as a 'relevant agency'. That said, the Executive recognised the challenges in how this might be practically discharged in terms of governance given the number of school / college leaders. However, this is not insurmountable. It requires further thinking about what the LSP status means in terms of accountability and how this can be discharged.

## THE CHSCP BOARDS

In mid-2021, the former CHSCP Executive group split to become two separate forums – The City of London Safeguarding Children Partnership Board and the Hackney Safeguarding Children Partnership Board. 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 core membership of the CHSCP Boards can be found HERE.

### ASSURANCE

The Boards in the City of London and Hackney met quarterly during 2022/23, with an additional combined meeting held in July 2022. 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 the Child Q review, the lessons arising from the national review into Arthur Labinjo Hughes and Star Hobson and multi-agency working, workforce health and stability and general progress. An extraordinary meeting focused on the cost-of-living crisis.

## THE CHSCP TEAM

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

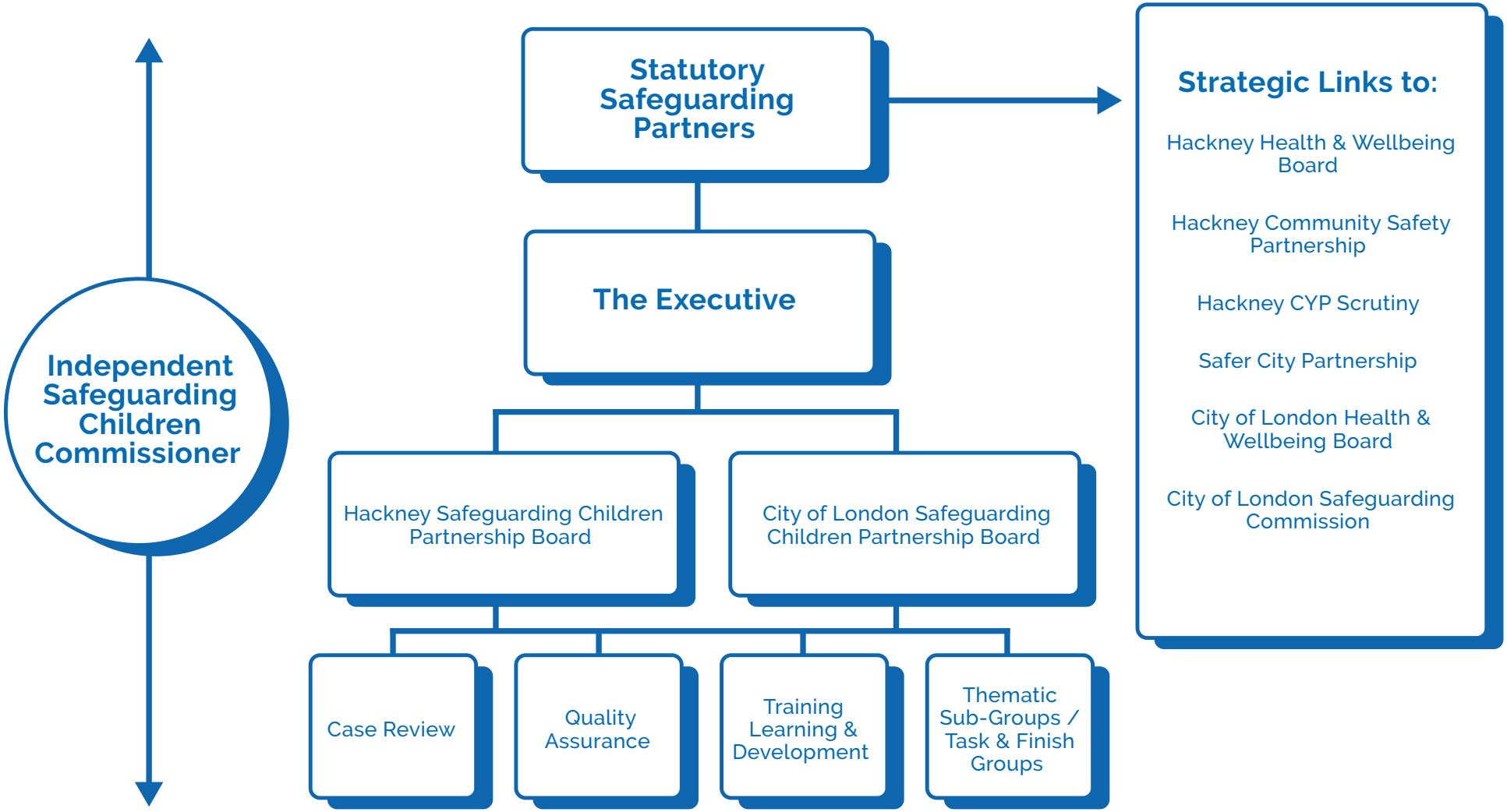
## RELATIONSHIPS WITH OTHER BOARDS / FORUMS

There was ongoing engagement with other strategic partnerships in the City of London and Hackney during 2022/23. This included the Health & Wellbeing Boards in the City of London and Hackney, Hackney's Community Safety Partnership, the Safer City Partnership and the City & Hackney Safeguarding Adults Board. The work of the CHSCP continued to feature as items for oversight by the political scrutiny functions in both areas.

### EVIDENCE

During 2022/23, a joint piece of work involving partners from the CHSAB and CHSCP was initiated to refresh the local 'Think Family' guidance. Arising from local learning identified in several reviews, this work is scheduled for completion in 2023/24.

# CHSCP Structure 2022/23



# Attendance

## HACKNEY EXECUTIVE

| Organisation | May 2022 | July 2022 | Oct 2022 | Jan 2023 | Agency Specific Attendance (%) |
|---|---|---|---|---|---|
| City of London Corporation | Yes | Yes | Yes | Yes | 100 |
| Hackney Council | Yes | Yes | Yes | Yes | 100 |
| Hackney Education | Yes | No | Yes | No | 50 |
| City & Hackney NHS North East London | Yes | Yes | Yes | Yes | 100 |
| Metropolitan Police Service | Yes | No | Yes | Yes | 75 |
| City of London Police | No | No | Yes | Yes | 50 |

## HACKNEY BOARD

| Organisation | May 2022 | Sept 2022 | Nov 2022 | Feb 2023 | Agency Specific Attendance (%) |
|---|---|---|---|---|---|
| CAFCASS - Children & Families Court Advisory & Support Service | Yes | No | Yes | Yes | 75 |
| Hackney Education | No | Yes | Yes | No | 50 |
| London Fire Brigade | No | Yes | No | No | 25 |
| Hackney Children & Families Service | Yes | Yes | Yes | Yes | 100 |
| Hackney Community & Voluntary Services | Yes | Yes | Yes | No | 75 |
| Homerton Healthcare NHS Foundation | Yes | Yes | Yes | Yes | 100 |
| NHS North East London (City and Hackney) | Yes | Yes | Yes | Yes | 100 |
| East London NHS Foundation Trust | No | No | Yes | Yes | 50 |
| Hackney Housing Services | Yes | Yes | No | Yes | 75 |
| Metropolitan Police Service | Yes | No | Yes | Yes | 75 |
| Probation Service | No | Yes | Yes | Yes | 75 |
| Public Health | No | Yes | Yes | Yes | 75 |

## CITY OF LONDON BOARD

| Organisation | May 2022 | Sept 2022 | Nov 2022 | Feb 2023 | Agency Specific Attendance (%) |
|---|---|---|---|---|---|
| CAFCASS - Children & Families Court Advisory & Support Service | No | No | Yes | No | 25 |
| City of London Corporation | Yes | Yes | Yes | Yes | 100 |
| London Fire Brigade | No | Yes | No | No | 25 |
| Homerton Healthcare NHS Foundation | Yes | Yes | Yes | Yes | 100 |
| City & Hackney NHS North East London (City and Hackney) | Yes | Yes | Yes | Yes | 100 |
| East London NHS Foundation Trust | No | No | Yes | No | 25 |
| City of London Police | Yes | Yes | No | Yes | 75 |
| Probation Service | No | Yes | Yes | Yes | 75 |
| Public Health | No | No | Yes | Yes | 50 |

# 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.

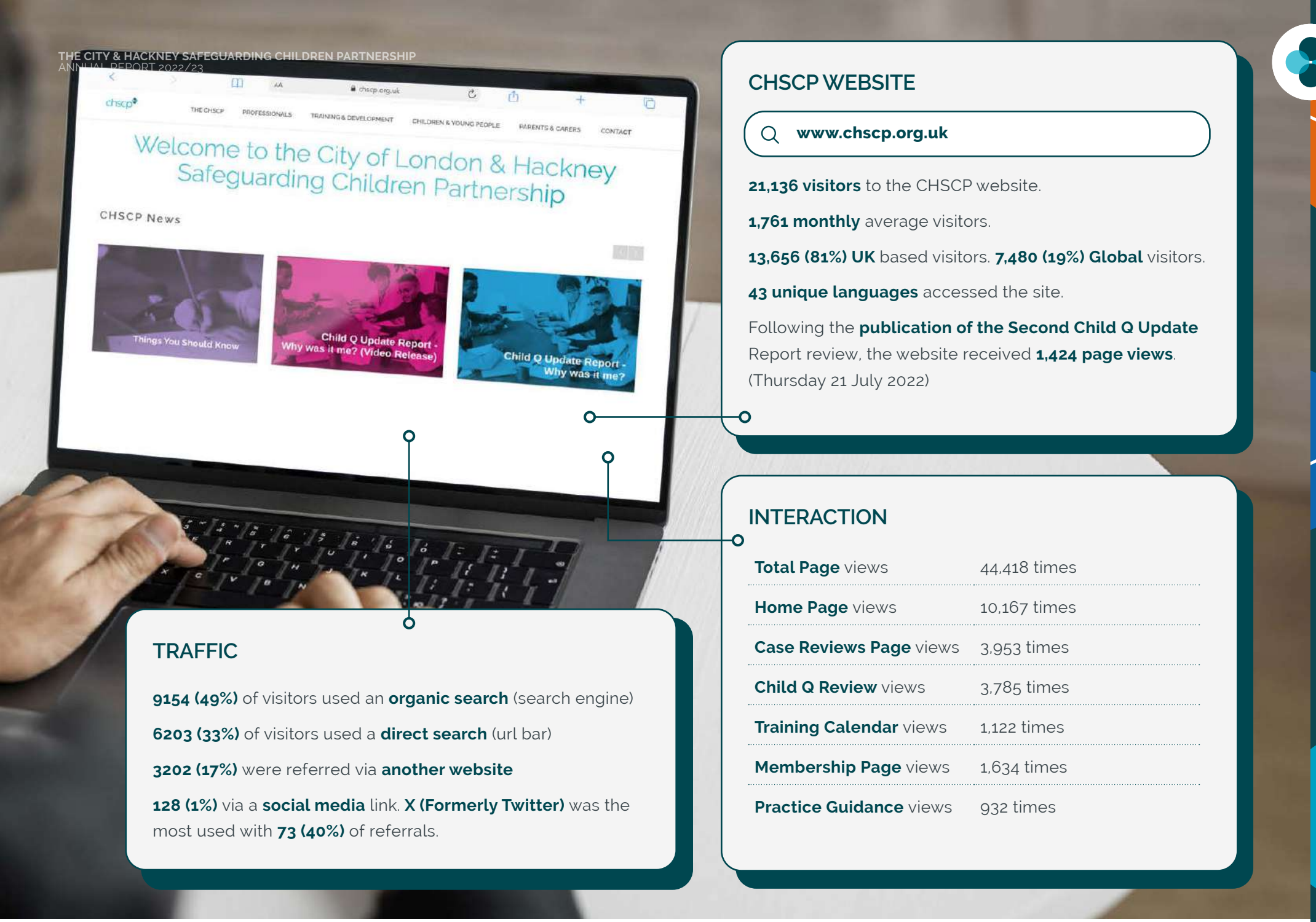
## EXPENDITURE

| | £ |
|---|---|
| Reviews | 24,700 |
| External Auditing | 2,750 |
| Staffing and Travel | 355,104 |
| Training, Learning & Development | 19,038 |
| Printing, Supplies & Equipment | 14,236 |
| Venues & Miscellaneous | 2,893 |
| **Total Expenditure** | **418,722** |

## INCOME

| | £ |
|---|---|
| Hackney Council (not including overheads) | 238,193 |
| City of London Corporation | 29,480 |
| Hackney Education | 24,480 |
| East London NHS Foundation Trust | 24,480 |
| North East London ICB247 | 12,000 |
| Homerton Healthcare NHS Foundation Trust | 12,000 |
| Metropolitan Police Service | 5,000 |
| Probation Service (London Division) | 2,000 |
| DFE Project funding (use of funding received in 2021/22) | 40,000 |
| **Total Income** | **363,153** |

# Communication




## CHSCP WEBSITE

**www.chscp.org.uk**

**21,136 visitors** to the CHSCP website.

**1,761 monthly** average visitors.

**13,656 (81%) UK** based visitors. **7,480 (19%) Global** visitors.

**43 unique languages** accessed the site.

Following the **publication of the Second Child Q Update** Report review, the website received **1,424 page views**. (Thursday 21 July 2022)

## TRAFFIC

**9154 (49%)** of visitors used an **organic search** (search engine)

**6203 (33%)** of visitors used a **direct search** (url bar)

**3202 (17%)** were referred via **another website**

**128 (1%)** via a **social media** link. **X (Formerly Twitter)** was the most used with **73 (40%)** of referrals.

## INTERACTION

| | |
|---|---|
| **Total Page** views | 44,418 times |
| **Home Page** views | 10,167 times |
| **Case Reviews Page** views | 3,953 times |
| **Child Q Review** views | 3,785 times |
| **Training Calendar** views | 1,122 times |
| **Membership Page** views | 1,634 times |
| **Practice Guidance** views | 932 times |

## X (FORMERLY TWITTER)

Within the time frame of 1st April 2022 - 31st March 2023, the posts promoting our TUSK (Things You Should Know) Briefings received 487 impressions.


## CHILD Q UPDATE REPORT

The Child Q Update Report was released in June 2023 and the post promoting the release has received **9,995 views** to date.


## CHILD Q UPDATE REPORT - VIDEO

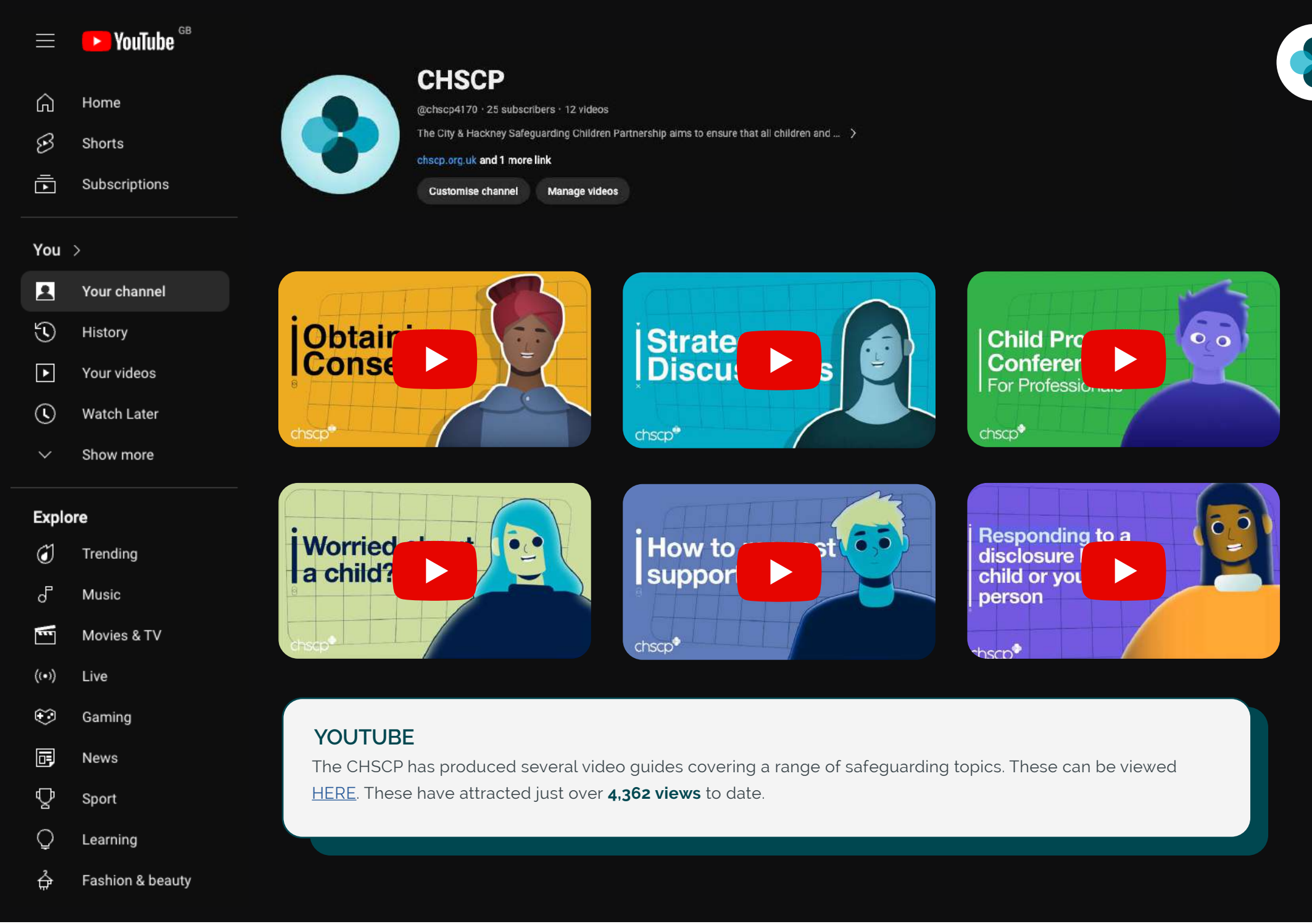
The Child Q Update Report Video was released in July 2023 and the post promoting the release has received **4,421 views** to date.

## 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 Things You Should Know, more commonly referred to as 'TUSK' briefings. These are circulated to subscribers and cascaded by safeguarding partners, relevant agencies and named organisations. The number of subscribers to the TUSK remained broadly static over 2022/23 with 1478 subscribers.




## YOUTUBE

The CHSCP has produced several video guides covering a range of safeguarding topics. These can be viewed HERE. These have attracted just over **4,362 views** to date.

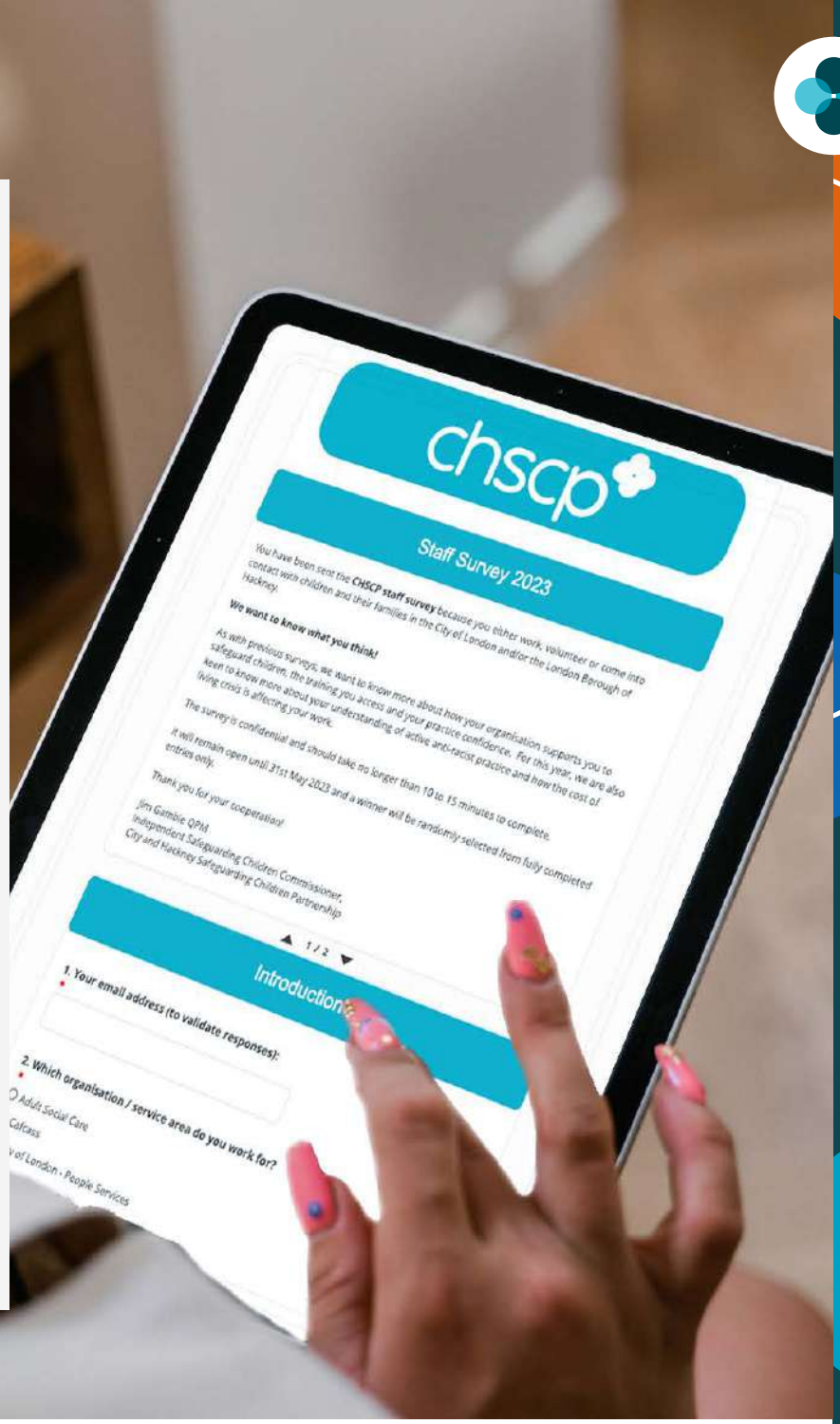
# Overview of Progress 2022/23

# PRIORITY 1

## The Health & Stability of the Safeguarding Workforce

**Progress:** During 2022/23, the CHSCP maintained its focus on the health and stability of the workforce as a key priority. There were three main ways in which this was undertaken. Firstly, through the development and launch of the CHSCP's Safeguarding Self-Assessment tool in February 2023. This tool is issued to all safeguarding partners, relevant agencies and named organisations and includes key questions about workforce sufficiency. An overview is included later in this report. Secondly, through the staff survey; establishing from practitioners themselves their views on issues such as management support, workloads and other potential workforce pressures. This too is covered later in this report under the Learning & Improvement section. Lastly, through the CHSCP's efforts in supporting the development of the safeguarding workforce through the provision of high-quality training, learning and development opportunities (see Training & Development).

In addition to these areas of activity, the CHSCP Executive and both Boards maintained clear oversight of these issues by way of the CHSCP risk register, where the health and stability of the workforce is a standing risk. Key areas of focus included the ongoing workforce pressures within CAMHS and the impact of the cost-of-living crisis. The cost-of-living crisis was considered at an extraordinary meeting of the CHSCP in July 2022, where reassurance was sought about the sufficiency of the arrangements in place to help mitigate the impact on children, their families and the safeguarding workforce. The health and stability of the workforce was a specific theme considered by the February 2023 Boards.



## PRIORITY 2

### *Active* Anti-Racist Practice

**Progress:** Much of the activity generated against this priority links with the CHSCP's work on the initial Child Q review and the Child Q update report published in June 2023. Details in this context are included under the Learning & Improvement section of this report. For individual organisations, section 8 of the Child Q update report provided an evaluation of the steps taken. These can be read HERE. Other actions taken include partners being much sharper on exploring issues of disproportionality. Most recently, this has been seen with HCFS identifying a potential practice issue relating to the triggering of child protection enquiries with Black African children where there are concerns about physical abuse. Whilst work is ongoing, this has led to some early conversations with a relevant charity seeking to develop improved preventative measures and awareness raising with children, families and practitioners.

## PRIORITY 3

### The Voice of Children and Young People

**Progress:** Again, the specific progress on how the voice of children, young people and families is 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. From the CHSCP's perspective, the engagement with nearly 100 children by the ISCC as part of the Child Q Update report demonstrated the priority placed on this aspect. The views captured have led to direct recommendations about wider engagement with children and young people, alongside developing mechanisms through which they can contribute to the independent scrutiny of our local arrangements.

# PRIORITY 4

## Getting the Basics Right

**Progress:** Work in Hackney has mainly focused on strengthening the way in which local early help arrangements operate - recognised as being key to effective help and protection. Work in the City of London has focused on maintaining these - with the local framework here being effective and established for several years. In addition, the CHSCP has maintained its priority on keeping its local policies and guidance up to date, routinely promoting these via its TUSK briefings. One key area that was explored during 2022/23 was Neglect. Building on its existing guidance and toolkit, the CHSCP commissioned the NSPCC's Graded Care Profile 2 tool with a view to implementing this across the partnership. However, after a significant amount of work developing our local infrastructure, on release of the tool itself, practitioners raised several concerns about its applicability in the context of local safeguarding practice. In summary, these concerns related to the scoring mechanism of the tool and the fact it was considered to be too Eurocentric in its foundations. After carefully considering the pros and cons of implementation, the partnership decided not to endorse its use. The City of London Corporation agreed to test the tool for a defined period and further decisions will be made at this stage.

# PRIORITY 5

## The Appetite to Learn

**Progress:** Progress against this priority remains strong. Whether through reviews, auditing or one of several mechanisms in operation, the CHSCP's Learning & Improvement framework continues to drive activity and identify lessons for practice improvement. Furthermore, our local focus on independent leadership and scrutiny via the ISCC remains a key component to our drive for improvement. With that in mind, it is of concern that the recent consultation by the Department for Education on the statutory guidance for safeguarding children, Working Together, appears to be diluting this. Whilst awaiting the outcome of the consultation, our local position on retaining independence in both partnership's chairing functions remains clear. For transparency, the collective response of the CHSCP's safeguarding partners on the DfE's proposal to remove independent chairs from local safeguarding arrangements was as follows:

*We are fundamentally opposed to this proposal. If implemented, this will significantly weaken how local arrangements operate in many areas, the significant majority of which retain an independent chair role. The requirement to mandate a partnership chair should be withdrawn from WT 2023.*

*The proposal to remove independent chairs and replace them with chairs from one of the three statutory safeguarding partners is defaulting back to a pre-Laming era and is therefore a step backwards.*

*The dilution of independence by removing independent chairs presents a risk. Lord Laming said partnership is about challenge. Healthy tension and grit are needed in the system for it to be truly independent and for it to work. There is a need to give Chairs and/or scrutineers teeth, not remove them.*

*Agencies have different priorities and will do what is right for them as individual agencies. Where agencies cannot agree, independence is needed. Chairs ask the questions that partners will not ask of each other.*

*It is important that partners do not mark their own homework or worse, decide not to do it at all. It is critical that one partner does not dominate the partnership. This proposal is a consensus model and therefore cannot work.*

*Independent Chairs do a lot more than turn up to meetings to chair them. For example, chairs hold escalation panels to resolve disputes. Locally, our independent commissioner decides whether the threshold has been met for a LCSPR. They have a role in independently advocating for and on behalf of children and families. These are functions beyond that of a 'scrutineer'. We believe strongly that there needs to be someone independent to make these decisions and deliver these functions. As an example, the Child Q Review would never have gone ahead if it had been left to the safeguarding partners.*

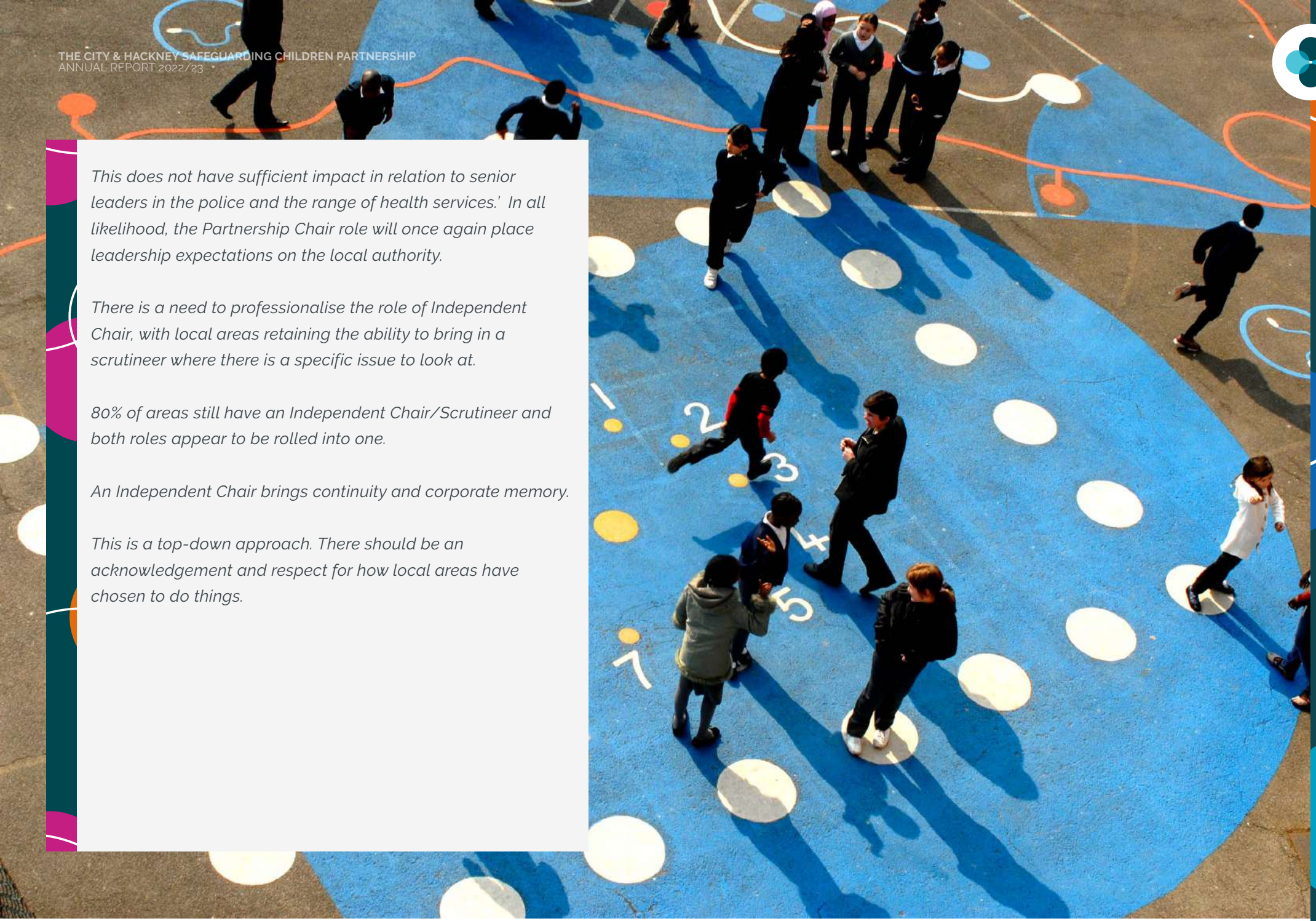
*The proposal is disconnected with what is happening on the ground and fails to recognise how the independent chairing of key partnership meetings is also a dedicated function of independent scrutiny, challenge and holding to account. Removing the independent chairing role would, for us, remove a key mechanism for independent scrutiny.*

*The Wood Review left choice for partnerships. Partnerships have chosen what works for them which includes retaining an independent chair – someone with insight and oversight.*

*Safeguarding children can be one priority amongst many for senior leaders of organisations. For independent chairs, it is their priority, and this helps drive an unswerving focus on children.*
*Based on the DfE sessions some of us have attended, this seems to be a fait accompli, but there is no substantive evidence that those areas who have adopted an approach without independent chairs are doing any better.*

*The DfE has been unable to provide specific exemplars to demonstrate which partnerships are working well under this type of arrangement.*
*It has not approached the City of London or Hackney, despite the fact that Ofsted highlighted good partnership arrangements in these areas.*
*One of the points of the Wood Review was about the quality of independent chairs. There has been an assumption made about the quality of individuals and we believe this has acted as a key catalyst for the proposals. This needs to be about system over personalities.*
*It is highly likely that in most areas, the DCS will be made the Partnership Chair. However, many will not have the capacity – some have broad spans of control, and some remain 'twin-hatters' and have responsibility for Adults Services and/or other functions such as Housing, Public Health etc.*

*In Sir Alan's initial report he highlighted "Despite the post of independent chair of the LSCB reporting to the local authority Chief Executive and statutory guidance on the role of the Director of Children's Services and the Lead Member, the situation is unsatisfactory and leadership expectations are focused on the local authority.*



*This does not have sufficient impact in relation to senior leaders in the police and the range of health services.' In all likelihood, the Partnership Chair role will once again place leadership expectations on the local authority.*

*There is a need to professionalise the role of Independent Chair, with local areas retaining the ability to bring in a scrutineer where there is a specific issue to look at.*

*80% of areas still have an Independent Chair/Scrutineer and both roles appear to be rolled into one.*

*An Independent Chair brings continuity and corporate memory.*

*This is a top-down approach. There should be an acknowledgement and respect for how local areas have chosen to do things.*

# PRIORITY 6

## Making the Invisible Visible

**Progress:** Progress has disappointingly but not surprisingly been absent in terms of the Unregistered Educational Settings (UES) agenda and its links to this priority area of the CHSCP. Notwithstanding the significant efforts by many of our local professionals, children who attend UES in Hackney continue to be outside the line of sight of safeguarding professionals. There is no direct mechanism to ensure that the premises within which they congregate are safe; that the infrastructure is sound; environment appropriate; or that contemporary safer recruitment practices are being applied to those working frequently and routinely with children. The comprehensive package of safeguarding support that was previously developed and shared with community leaders has received no uptake and based on the conditions seen at some UES (via the UES protocol meetings), this remains a significant concern. Equally concerning is the ongoing legislative vacuum that facilitates the operation of UES as they are. The redaction of the Schools Bill, alongside the absence of any meaningful cooperation from those responsible for UES, is not making children who attend UES safer.

# City Safeguarding Snapshot 2022/23

**765** children and young people under 19

**5.4%** of total population

**14.5%** of children in primary schools in receipt of free school meals

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

**29** Team around the Child (TAC) meetings held

**3** young people going missing from care (12 incidents)

**2** incidents of children & young people missing from home

**707** contacts to the City Children & Families Team Hub

**63** referrals

**30%** re-referrals

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

**89%** of assessments completed within 45 days

**11** child protection investigations

**2** children on a Child Protection Plan as of March 2023

**131** Children in Need episodes as of March 2023

**9** children & young people looked after as of March 2023

**1** MARAC meeting involving children

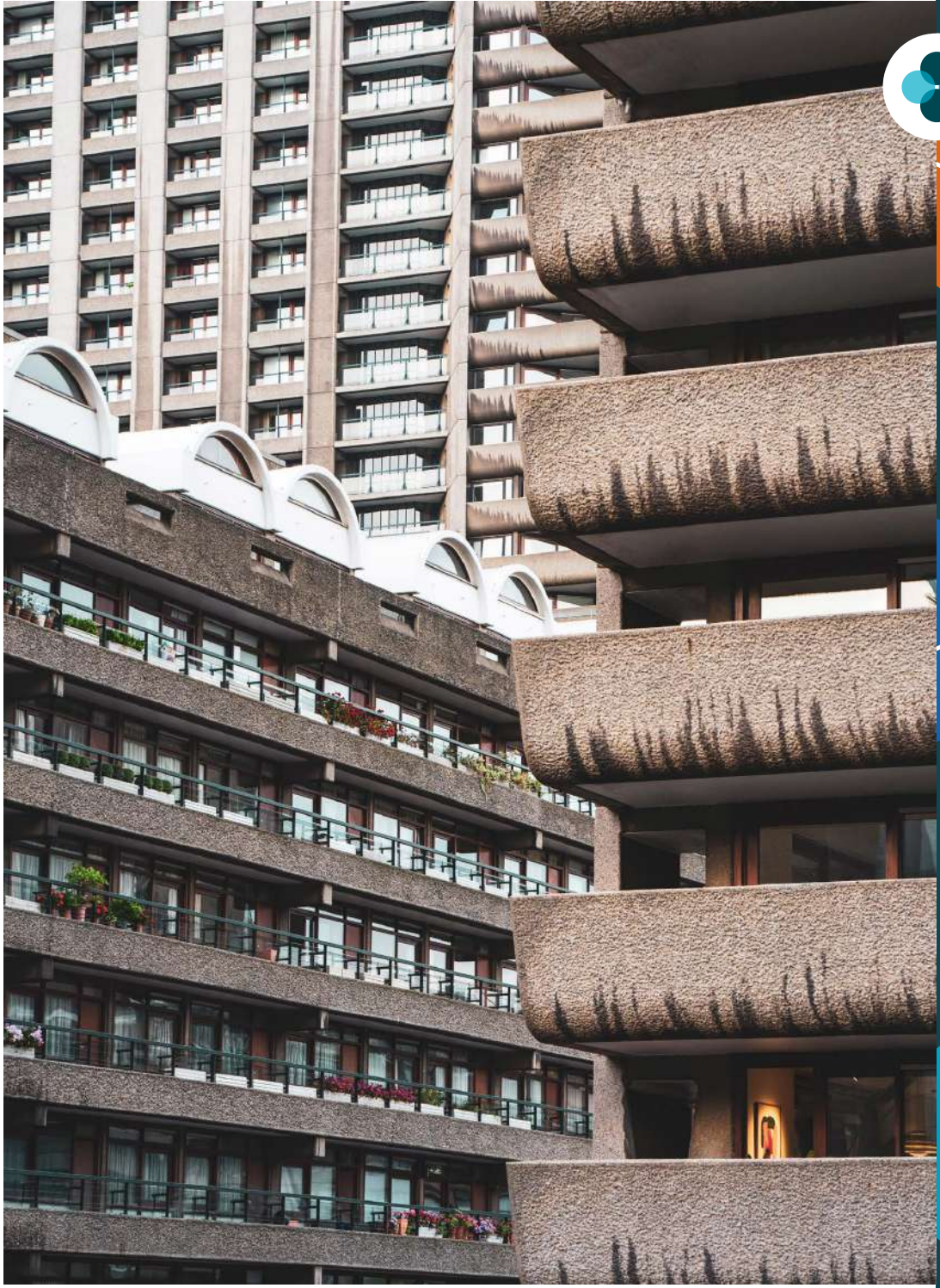
**13** referrals to the LADO

**0** Private Fostering arrangements as of March 2022

# Safeguarding in The City of London

# City of London Demographics

The City of London has an estimated resident population of about 10,847 people (ONS, November 2023) and approximately 587,000 workers. City jobs have grown over 15% between 2017 and 2021, with nearly 75,000 more jobs than in 2017. Of the resident population, 2468 children and young people (0-25) live in the City of London with 765 under the age of 19 and 580 under the age of 15. The City of London is an economically diverse area, with its population characterised by areas of affluence and poverty. Within the Square Mile, there are large disparities. The Barbican West and East residential areas are among the most affluent areas in England. Portsoken Ward, however, is among the most deprived. The Bangladeshi community makes up 3.3% of the total population. Poverty and overcrowding in housing were identified as significant issues in children's wellbeing as well as the Covid 19 pandemic. The pandemic increased the demand for mental health and speech and language services, and had a detrimental impact on children's personal, social, and emotional development. Within the City, there is one maintained primary school (with a Children's Centre attached), four independent schools and several higher educational establishments. It has no maintained secondary schools. 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.



# Early Help

Early help services across the City of London are delivered by People's Services and a range of partners, including schools, children's centres, one GP surgery and health colleagues as well as other local service providers, including the community and voluntary sector. They are effective, and some are particularly strong. The range of services available to children, young people and their families in the City continue to adapt and evolve based on the needs of the local population. The early help arrangements in the City have been in place now for several years and are embedded with agencies. All children needing an early help service in the City receive a well-resourced, dedicated service, which is provided by trained staff. Over 2022/23, the Early Help Strategy for the City of London continued to drive partnership improvements. With a focus on ensuring the right help is provided at the right time and in the right place, the strategy is focussed on key strategic objectives and is coordinated by the CHSCP City Early Help Sub-Group. Through critical reflection, consultation and co-production with children and families, partners from the Multi-Agency Practitioners Forum and the City's Parent Carer Forum for children with SEND, the following progress has been made:

### EVIDENCE

In 2022/23, the total number of cases referred or stepped down to early help services was 58, an increase on the 40 in 2021/22. There were no re-referrals to early help within 12 months of closure. This has been a consistent pattern and reflects the effectiveness of the multi-agency intervention in the City to improve outcomes for children and young people, preventing problems getting worse.

### ASSURANCE

*'The City of London Corporation provides effective front door arrangements through a multi-agency safeguarding hub (MASH). Although professionals are not all physically co-located, the service ensures that children receive timely and responsive social work and early help services. Thresholds are clearly understood by professionals. Partners have good access to social work consultation. This helps to ensure that children are referred for the appropriate level of service, and that intervention is timely.'*

Ofsted, December 2022

### ASSURANCE

*'When decisions are made to step children's cases down to early help services, children receive high-quality assessments that identify their needs well. This leads to skilful early intervention that improves children's circumstances and prevents concerns escalating.'*

Ofsted, December 2022

## ASSURANCE

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

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

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

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

# Children in Need of Help and Protection

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

### ASSURANCE

*'Children who require statutory services receive a timely assessment of need. Assessments are child-centred, of high quality and clearly identify and analyse risk, need and strengths. This supports effective care planning.'*

Ofsted, December 2022

### ASSURANCE

*'Children at risk of harm are identified promptly. Strategy discussions are timely and are well attended by multi-agency professionals. This ensures that effective information is shared in order to inform risk assessments, so that prompt decisions and actions can be made to safeguard children.'*

Ofsted, December 2022

### ASSURANCE

'MASH health contributes to the City of London (CoL) virtual MASH through participating in strategy discussions, representing health, gathering health information for MASH checks, and identifying / facilitating appropriate health professionals to participate in strategy meetings. Working with the Homerton informatics team the data has now been disaggregated to show CoL strategy meeting requests and CoL MASH information/health checks for data gathering in 2022/23. The working arrangements for the CoL virtual MASH and MASH health have been further embedded in CoL practice, which resulted in 14 health requests for MASH checks (+4 from 2021/22) and seven strategy discussions participation.

# Contacts, Referrals and Assessments

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

## EVIDENCE

The 707 contacts made to the Children and Families Hub reflects a further increase in activity (551 in 2021/22 and 259 in 2020/21). Referrals decreased to 63 from 139 in 2021/22. The re-referral rate in the City of London increased from 15% to 30%. Notwithstanding the increased demand during 2021/22, the performance data in the City continues to be indicative of a good social work response and timely access to appropriate support that helps children and their families.
The Children and Families Team completed 59 assessments during 2021/22, compared to 38 in 2020/21. 71% of assessments were completed within 45 days or less. Child protection activity increased significantly. There were 23 child protection (Section 47) enquiries in 2010/22, compared to just five in 2020/21.

## ASSURANCE

Despite the clear challenges arising from identification of need and risk, children continued to receive a swift service during 2022/23 when safeguarding concerns became apparent. All Section 47 enquiries undertaken in the City are led by a suitably qualified and experienced registered social worker.

# Children on Child Protection Plans

Following a child protection enquiry, where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an Initial Child Protection Conference (ICPC). An ICPC brings together family members (and children / young people where appropriate) with supporters, advocates and professionals to analyse information and plan how best to safeguard and promote the welfare of the child / young person. If the ICPC considers that the child / young person is at a continuing risk of significant harm, they will be made the subject of a Child Protection Plan (CPP). Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how professionals, the family and the child or young person (where appropriate) will know when progress is being made. Two children were subject to a CPP in the City at the end of 2022/23.

# Children in Care

A child or young person who is 'looked after' is in the care of the local authority. They can be placed in care voluntarily by parents struggling to cope, they can be unaccompanied asylum-seeking children; or in other circumstances, The City of London Corporation and partners will intervene because the child or young person is at risk of significant harm. As of 31 March 2023, the City of London Corporation was responsible for looking after nine children and young people, a reduction from 11 in the previous year. There were 21 looked after children throughout 2022/23 - a reduction of 30% from the 30 in 2021/22. The City of London's rate for looked after children is well above statistical neighbours and proportionately, this reflects a high volume of work for the City of London social workers.

## PLACEMENT STABILITY, TYPE AND LOCATION

Of the nine children in care at the end of the reporting year, three were in foster placements, four children were in semi-independent provision, one child was in a residential school for children with disabilities and one child was in a mother and child placement.

In 2022/23, no looked after child had three or more changes of placement and for those in placement for over 2.5 years, all had been in the same placement for two years or more. This continues to reflect good performance and means that children looked after by the City tend to enjoy good stability and placements that meet their needs well. The local authority does not have its own fostering service due to the size of the looked after children population, but spot purchases from the Pan-London consortium. Ofsted rates all independent fostering agencies used by the City either Good or Outstanding. There are sufficient suitable placements available to meet the needs of the City's looked after children and young people. All placements are outside of the local authority.

### ASSURANCE

*A positive development in the last reporting year was the introduction of a new 'Home Panel'. The purpose of the panel is to have a service wide discussion about the implications of moving a young person if their placement is presenting as unstable. This may be due to the placement expressing concerns or the young person expressing a wish to move. Included in the panel is the Head of the Virtual School so they can have an input into the impact on a child's education if they were to move. Also present are members of the commissioning team so they can advise on placement availability. The panel can be called to meet at short notice if there is an unexpected placement disruption. This has strengthened the multi-agency planning around care placements, taking into account the child's hoslitic needs. It has created greater senior management oversight of placements moves, and increased consistency in relation to care planning decision making for all children.*

City of London IRO Annual Report 2022/23

## Care Leavers

There is a strong range of support for care leavers in the City of London. They are well supported, workers remain in touch with them, there is availability of suitable accommodation, and they are provided with health support. At year end, there were 59 care leavers. 52 out of 59 care leavers were in education, training or employment, 88% had an up-to-date pathway plan and 55/59 were considered to be in suitable accommodation.

## Violence Against Women and Girls

Children and young people who are exposed to domestic violence and abuse can grow up in a vacuum of what is expected in terms of a positive and healthy relationship. This can create additional vulnerabilities and/or harmful behaviours. Responding proactively and in collaboration with the Safer City Partnership (SCP), violence against women and girls remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. During 2022/23, the SCP continued its focus on implementing the City of London Violence Against Women and Girls Strategy.

## MARAC

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

**EVIDENCE**

In 2022/23, seven cases were considered at City's MARAC, with one case involving children.

# Safeguarding Adolescents

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

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

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

**ASSURANCE**

*'Leaders use intelligence and data from partners well to inform a multi-agency response to risk of extra-familial harm. For example, the work in Multi-Agency Child Exploitation meetings is used effectively in order to track emerging themes that happen in the City of London. The co-chairing of this meeting by the police and children's services, with good attendance from other agencies, has allowed partners to develop creative ways of identifying and dealing with a range of issues, and to tackle complexity as early as possible in order to better protect the most vulnerable children. This includes responding to low-level gang activity in order to prevent concerns escalating and identifying children who are vulnerable to trafficking.'*

Ofsted, December 2022

**ASSURANCE**

A forensic CAMHS worker has been added to the team, funded through the London health offer to work once a month as of August 2022. This service is open to all children and young people in the service, but with a particular focus on vulnerable children and young people presenting with complex mental health needs and high-risk behaviours to support them to understand and reduce any risks they may face or pose and prevent escalation into criminality.

# Child Sexual Exploitation

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

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

DfE 2017

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

# Children Missing from Home, Care and Education

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

### ASSURANCE

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

### ASSURANCE

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

### ASSURANCE

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

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

# Gangs, Criminal Exploitation and Serious Youth Violence

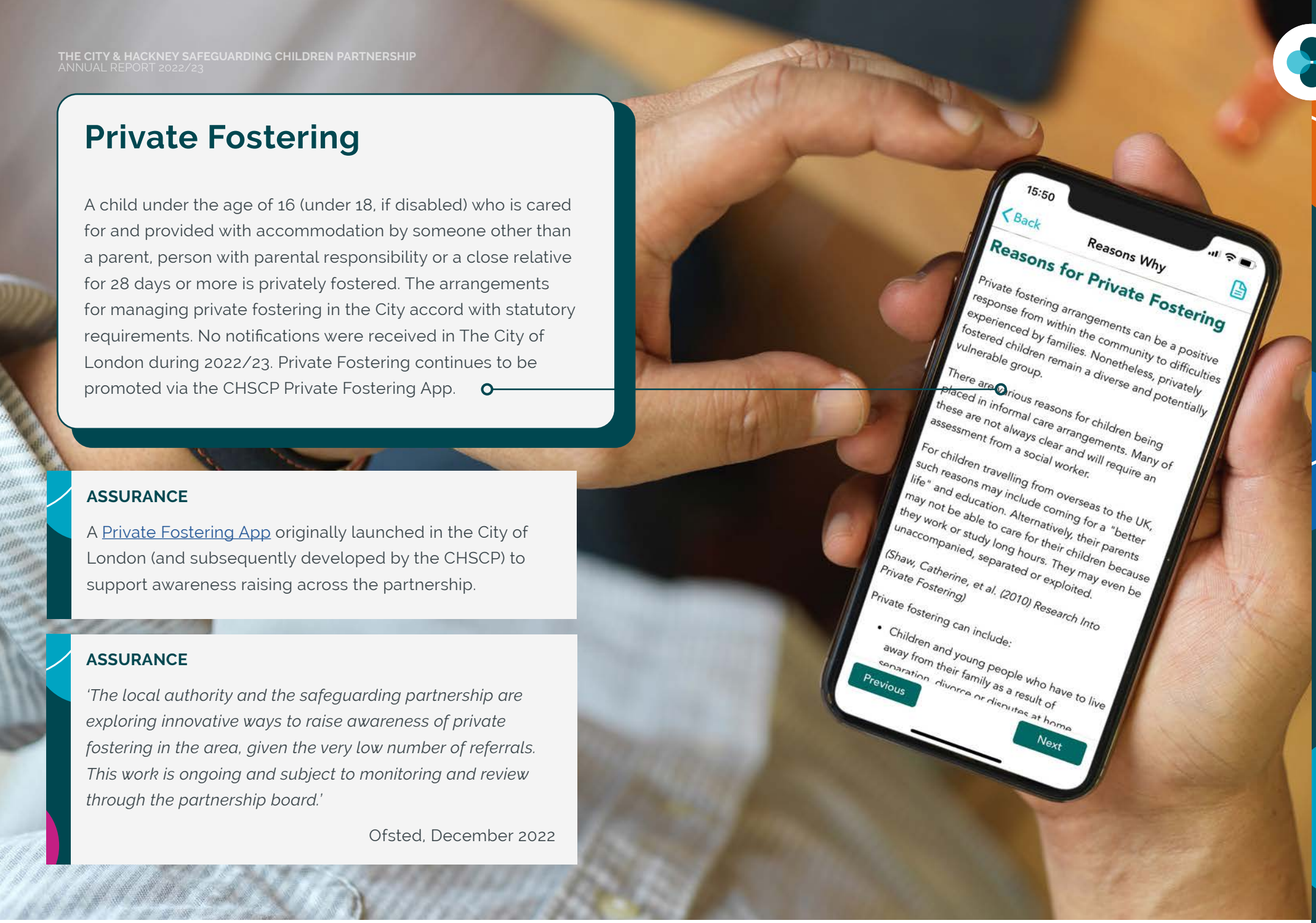
There are several ways in which young people can be put at risk by gang activity, both through participation in and as victims of gang violence which can be in relation to their peers or to a gang-involved adult in their household. The City of London Drugs Profile found that the largest area of drug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

# Radicalisation

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

# Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. The arrangements for managing private fostering in the City accord with statutory requirements. No notifications were received in The City of London during 2022/23. Private Fostering continues to be promoted via the CHSCP Private Fostering App.




## ASSURANCE

A Private Fostering App originally launched in the City of London (and subsequently developed by the CHSCP) to support awareness raising across the partnership.

## ASSURANCE

*'The local authority and the safeguarding partnership are exploring innovative ways to raise awareness of private fostering in the area, given the very low number of referrals. This work is ongoing and subject to monitoring and review through the partnership board.'*

Ofsted, December 2022

# Children with Disabilities

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

## EVIDENCE

The City of London provided short breaks to 11 children supported by Early Help and there were 22 children with EHC plans over 2022/23. There is a disability lead in the social work team who has specialist knowledge and supports the service when needing to progress assessment work with disabled children. Partners have continued to offer close support to children with EHC Plans and their families through a strong integrated offer between Special Educational Needs and Children's Social Care.

# MAPPA

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

## EVIDENCE

Across London on 31 March 2023, there were 6901 Category 1 'Registered Sex Offenders' (RSOs) (6700 in 2021/22, 6549 in 2020/21, 6581 in 2019/20 and 6452 in 2018/19), 3669 Category 2 'Violent Offenders' (3660 in 2021/22, 3521 in 2020/21, 3735 in 2019/20 and 4128 in 2018/19) and 51 Category 3 'Other Dangerous Offenders' (55 in 2021/22, 61 in 2020/21, 31 in 2019/20 and 27 in 2018/19). 158 RSOs were cautioned or convicted for breach of notification requirements. (153 in 2021/22)

## LEARNING

*Whilst scheduled for publication in early 2024, the following extract from the report into Case A (a Hackney case) provides an insight into the challenges being faced in this area of safeguarding.*

*For individuals known to have committed child sex offences, they will always present a risk to children. What this looks like will vary from offender to offender and can change over time, but there will never be no risk at all. Accepting this fact must be the starting point for everyone working with children, their families and offenders themselves. It reflects an unambiguous safeguarding first approach and there should be no practice within our system that dilutes this position. Time served in prison, sex offender courses, dynamic assessment and monitoring can all have the potential to reduce recidivism. However, what they can't do is change the fantasies of those with a deviant sexual interest in children or predict with absolute certainty who will go on to re-offend. It is factors such as these that make the management of child sex offenders so complex and why the paramountcy of child protection must always steer the decision making and actions of practitioners.*

*Beyond this complexity, we also know there continues to be a growth in activity and that resource pressures on public services remain. Combined, these circumstances have created somewhat of a 'perfect storm' that is placing immense strain on those agencies responsible for this work, particularly the police. As highlighted in the independent review by Mick Creedon QPM, because of this environment the system needs to work differently. We agree.*

*However, whilst accepting there are no easy answers, we don't believe that system change should correlate with a system doing less. Many would see this as counter-intuitive, and yet solutions continue to be promoted that focus on a reduction in activity to cope with demand. This has largely, but not exclusively, focused on those perceived as being 'low risk offenders' and/or 'viewers' of indecent images.*

*As far back as 2017, the former child protection lead for the National Police Chief's Council (NPCC) raised concerns about the volume of offending and that the police had reached 'saturation point' in terms of its capacity to respond. He argued there was a need to look at alternatives to custodial sentences, including prevention and rehabilitation, although the monitoring of offenders would continue. More recently, the report by Mick Creedon QPM recommended changing the monitoring regime itself by introducing discretion, reducing timescales and allowing for more flexibility in decision making.*

*All these points can be seen as an understandable response to the demand / resource conundrum that the police are facing. That said, it is hard to see how any of them will make children safer. Tweaking the system will weaken the system and doing less won't address the fundamental challenges in this space. What is perhaps more likely is that additional fault-lines will appear in the form of harm. Based on the lessons from this review, we believe there are opportunities to do more. More by way of harnessing the insights of others to help improve the monitoring of offenders, mitigate risk and increase protection. This can only happen with improved partnership arrangements and information sharing.*

Jim Gamble QPM & Rory McCallum, SPA

# Afghan Families Resettlement Project

The Afghan Resettlement Programme was established in the City of London in August 2021 in response to the placement of around 500 Afghan people in 2 bridging hotels in the City of London. This included around 250 children. The Afghan Families have been supported by the Children and Families service working in partnership with other teams and organisations to access education and school places, register for healthcare services, including Covid vaccination services and access to community groups and services.

Responses to the conflict in Ukraine, including the Homes for Ukraine programme and Family Visa Scheme have also arisen within this reporting period. The service has helped families when needed, including those who have children with a Special Educational Need or Disability. Examples of the support provided include sourcing suitable school placements, employment and housing.

**IMPACT**

The Health Visiting team from Homerton Healthcare NHS Foundation Trust, working alongside key stakeholders including Aldgate Children's Centre and the Multi Agency Safeguarding Hub (MASH) in the City of London were instrumental to the joined-up approach to support the Afghan families who were in temporary housing. Key challenges for the families included the constraints of living in temporary hotel accommodation; uprooted from strong family and social ties, illiteracy amongst the women and access to GP and dental appointments. Working together resulted in a family with a child with complex special needs rehoused in the City.

**IMPACT**

*'Good political and corporate support for children's services has helped children's leaders deliver a remarkable service to Afghan children and families through their resettlement programme. The co-location of the early help lead, adviser for early years and social work managers supports timely and effective communication, and consultation between services. This strength of joint working underpins effective support being provided for the children and families. For example, leaders liaised extensively with partners to quickly coordinate and mobilise services, including deploying a dedicated early help practitioner to support the Afghan children. The creative and innovative partnership also created a bespoke learning centre and a play centre for over 320 children within one week of the children arriving in London. The council and its partners worked collaboratively to secure education provision for all school-aged children, in time for them to start the new school term alongside their peers.'*

Ofsted, December 2022

## EVIDENCE

Recognising the new environment in which families would be living, the CHSCP partnered with the Royal Society for the Prevention of Accidents to issue translated material for families in both Pashto and Dari.

# Safer Workforce

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

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

## IMPACT

*'The local authority designated officer provides a robust service, taking a forensic approach to analysing current and historical information, and making timely and effective decisions. The designated officer also provides skilled professional challenge to organisations when necessary.'*

Ofsted, December 2022

## EVIDENCE

**Activity** - There were 13 referrals made to the LADO during 2022/2023, slightly lower than the 15 in 2021/22. Sources of referrals were varied, with the highest proportion coming from other Local Authorities. There was also a further increase in referrals from employment agencies based in the City of London (covering health, social care and education). Concerns from this sector involved allegations that occurred outside of the City of London (where the professionals worked). Whilst the City of London LADO provided support and advice, all these allegations were managed by the LADO in the area they occurred. Positively, there have been two referrals from the City of London Police (and one from the MPS).

## EVIDENCE

Of the 13 referrals received, only one referral required an Allegation Against Staff and Volunteers (ASV). Of the 12 remaining referrals, two did not meet the threshold for LADO involvement, and the remaining 10 required advice and support from the LADO in managing the concerns. In most of these cases the allegation is dealt with by the LADO in the area where the incident occurred. However, if the agency of the professional is based in the City of London, then the LADO would support that agency in managing the potential risks regarding the individual and advise on any safer recruitment concerns.

## EVIDENCE

**Themes** - Of the 13 referrals received, four fell under the category of sexual, three were physical, four related to the individual's behaviour and two involved concerns in relation to the individual's personal life.

## IMPACT

The role of the City of London LADO often involves supporting agencies in getting information about the allegations, as it can be difficult getting hold of individuals working in other Local Authorities or Police Forces. The support from the City of London LADO in obtaining this information assists in the management of risk and disciplinary processes as required.

## IMPACT

Training on the LADO role was offered in March 2023, by the City of London and Hackney LADO, via the CHSCP, take up of this training was limited from both City and Hackney, this may have been due to the training being face to face. New staff in the City of London from the Peoples Directorate meet with the LADO as part of their induction process, and going forward there will be face to face induction days for staff, where training on the role of the LADO will be covered.

## ASSURANCE

The responsibility of the LADO is set out in Working Together to Safeguard Children 2018 and Chapter 7 of the London Child Protection Procedures (7th edition). All allegations made against staff, including volunteers, that call into question their suitability to work with or be in a position of trust with children, whether made about events in their private or professional life, need to be formally reported to the LADO. Chapter 7 of the London Child Protection Procedures has recently been amended to provide consistency in respect of the response to low level concerns and to include the wider definition of people in 'Positions of Trust' (The Police, Crime, Sentencing and Courts Act 2022 has extended the definition of Position of Trust within the Sexual Offences Act 2003 section 22A to include anyone who coaches, teaches, trains, supervises or instructs a child under 18, on a regular basis, in a sport or a religion).

## ASSURANCE

In January 2022, the CHSCP Executive discussed the interface between the police and the Local Authority Designated Officer (LADO). This related to the absence of routine contact from the police concerning conduct matters that meet the threshold for the LADO to be notified. This has been an ongoing issue for some time and is not unique to the City of London or Hackney. A Pan-London group looked at solutions, although work was placed on hold due to COVID-19 and subsequently stalled. With the agreement of the Executive, a small group was scheduled to meet to discuss the possibility of a local protocol, although for a variety of reasons, this did not go ahead.

Given there remained no consistent mechanism allowing for oversight on possible LADO issues concerning the police, the ISCC wrote to Commanders in both the City of London and Hackney seeking their cooperation in this regard. The request has been relatively simple in that the City Police and CE BCU should include a trigger point within their processes to notify the LADO of any case that meets the criteria. This will not interfere with conduct procedures and will create immediate alignment with other safeguarding partners and relevant agencies. At present, the police remain an outlier to working within our defined safeguarding arrangements and procedures, although it is positive to note the three police contacts to the City LADO in 2022/23.

# Hackney Safeguarding Snapshot 2022/23

- Approximately **55,059** children and young people under 18
- **21%** of total population
- **24.7%** of under 16s live in a low income family
- **37.9%** of primary pupils eligible for free school meals
- **42.6%** of secondary school pupils eligible for free school meals
- **580** families with children under 5 received Early Help MAT intervenion
- **394** new early help cases identified and supported through the MAT process
- **14,248** contacts to Hackney CFS
- **4,148** referrals
- **20%** re-referrals
- **3,998** assessments completed by Hackney CFS
- **69%** of assessments were completed within 45 days
- **1,326** child protection investigations
- **181** Children on a Child Protection Plan as of March 2023
- **392** children & young people looked after as of March 2023
- **327** MARAC meetings involving children and young people living in families with domestic violence
- **355** contacts to the LADO
- **10** Private Fostering arrangements as of March 2023
- **16,811** young people accessed universal services offered through Young Hackney
- **1,410** young people received targeted support through Young Hackney
- **185** children entered care during 2022/23
- **409** care leavers aged between 17 and 21 were being supported by the Leaving Care Service
- **291** children allocated for direct work with the Clinical Service in 2022/23

# Safeguarding in Hackney

# Hackney Demographics

The London Borough of Hackney is an inner-city London borough. The ONS estimates there were **261,491** people living in Hackney in November 2023 with **21.1%** of its population aged under 18 (**55,059** children). Hackney is a culturally diverse area, with significant 'Other White', Black and Turkish/Kurdish communities. A large Charedi Jewish community is concentrated in the North East of the borough and is growing. Hackney was the 22nd most deprived local authority in England in the 2019 Index of Multiple Deprivation, in 2015, it was ranked 11th, and in 2010 it was ranked second. It is relatively more deprived in relation to barriers to housing and services. income and living environment than its overall rank suggests, but generally less deprived than its overall ranking for crime, employment and health and significantly less deprived for education. At GCSE the average Attainment 8-point score per pupil in Hackney was **54** points, this was higher than the London average of **50.6** points. The borough experienced a slight decline in the incidents of crime. The average number of open cases in 2020-21 was 648. In 2021/22 this reduced to 620. However Hackney's crime rate is 22% higher compared to the rest of London and 38% higher compared to the national average.

**For additional context, reference should be made to the Hackney CFS Annual Report for 2022/23. This includes more detailed information covering data, progress and the quality assurance activity covering key safeguarding and child protection processes.**

# Early Help

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

## ASSURANCE

Between 2019-2022, Hackney Council undertook a review of its Early Help Model in consultation with parents and young people, schools, partner agencies and staff. Over the reporting year, the Council produced a refreshed vision for Early Help in Hackney and began implementing a series of operational changes that were required.

## IMPACT

The introduction of a shared set of Early Help Practice Standards.

One 'Request for support' form which will all be screened by the Early Help Hub.

A consistent step-up/ step-down protocol between Children's Social Care and targeted Early Help.

The Hackney Wellbeing Framework will continue to be embedded across Early Help services.

One case-management system for all Early Help services, with the ability for improved information-sharing with partners, in-line with GDPR and consent. (HCFS Annual report 2022/23)

## IMPACT

The maternity safeguarding team at Homerton Healthcare NHS Foundation Trust have been involved in several projects this year; **Removal at Birth, Hope box project** – Homerton are a pilot site for this project which is a joint initiative from The Centre for Child and Family Justice Research at Lancaster University, Birth Companions, and the PAUSE project. HOPE boxes (Hold on Pain Eases) have been put together by women with lived experience with the support of these organisations to enable women at risk of care proceedings to have the opportunity to create connections and build support. The boxes enable midwives and families to have discussions around care planning and aim to support women during this difficult time. This feeds into a larger QI project at Homerton around Separation at Birth. A Trauma Informed Care Plan and Guideline have been developed to support this work and we have now given out 4 sets of boxes which have been very well received by women and midwives.

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

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

## YOUNG HACKNEY

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

### IMPACT

An estimated total of 16,811 young people accessed universal services offered through Young Hackney during 2022/23, based on 154,030 named and anonymous attendances. This is in line with 16,676 accessing Young Hackney Universal services during 2021/22. Young Hackney delivered targeted support to 1,410 young people in 2022-23, which is in line with the previous year (1,471 in 2021/22). (HCFS Annual Report 2022/23)

# Children in Need of Help and Protection

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

## CONTACTS, REFERRALS AND ASSESSMENTS

During 2021/22, Hackney redesigned its First Access & Screening Team to a Multi-Agency Safeguarding Hub (MASH) model. This now acts as the single point of contact for referrals to Children's Social Care in Hackney and provides responsive screening activities. The move to a MASH aligns Hackney with most other LA areas. Alongside integrating an Early Help Hub within the MASH and revisions to the Hackney Child Wellbeing Framework, a MASH consultation line was also introduced to help practitioners navigate issues such as consent and thresholds for intervention.

### EVIDENCE

The Hackney MASH received 14,248 contacts from a range of sources of which 29% were accepted as a referral to CFS (29% in 2021/22). This remains less than the number of contacts and referrals pre-pandemic (2019/20), but an increase from the last reporting year (12,313). Referrals also increased by 16% (from 3559 to 4148). The percentage of cases which were re-referrals (which had been open in the last 12 months) was 20%. This is in line with the national average and slightly above statistical neighbours (18%)

### ASSURANCE

*Purposeful work has been undertaken through the revision of the Hackney Child Wellbeing Framework, the shift to a Multi-Agency Safeguarding Hub, an Early Help Hub, changes to the way contacts are recorded and the introduction of a consultation line. The positive impact of the consultation line means that requests for support not meeting statutory intervention are not processed as contacts. However, there is still some 'oversharing' from some agencies, mainly the Police, which is being addressed.*

(HCFS Annual Report 22/23)

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

### EVIDENCE

3998 assessments (718 per 10k) were completed in 2022/23, an increase of 23% compared to 3858 and 3244 assessments in 2020/21, 2021/22 respectively. Hackney's current rate of assessment is above the average for statistical neighbour authorities (589 per 10k).

### EVIDENCE

Last year, performance in relation to the timescale for the completion of assessments within 45 working days was on a trajectory of improvement. 93% of assessments during the first quarter of 2021/22 were completed within 45 working days. At the end of 2021/22, this was 82% compared with 78% for 2020-21. However, in early 2022/23, there has been a notable decline. The end of year percentage for 2022/23 was 69%. Reasons for this as set out by Hackney Children & Families Services included the reintroduction of the Mosaic recording system, some notable staff challenges as a result of staff sickness (including due to COVID-19), staff changes and some performance management concerns. Management oversight and accountability has improved, and assessment timeliness has steadily improved: it is currently at 82% for April to September 2023.

### EVIDENCE

1326 Section 47 investigations (child protection investigations) began in 2022/23, an increase on 825 the previous year. This represents a rate of 238 Section 47 investigations per 10k, which is more than statistical neighbours (203 in 2021/22) and the England average (180 in 2021/22). 23% of Section 47 investigations progressed to an Initial Child Protection Conference in 2022/23, a decrease from 32% in 2021/22. This is lower than statistical neighbours (31% in 2021/22) and lower than the England average (34% in 2021/22).

### EVIDENCE

In 2022/23, 67% of assessments completed resulted in no further statutory social work action, a slight decrease compared to 70% in 2021-22. As at the end of September 2023, this rate remained the same at 67%.

## STRATEGY DISCUSSIONS

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

### ASSURANCE

The CHSCP Quality Assurance Sub-Group maintains oversight of the quality of strategy discussions via audit and tracks the progress of multi-agency improvement actions. The most recent audit was commissioned using external auditors in March 2022. Broad findings in audit rounds demonstrated good timeliness, with evidence of sufficient information sharing, understanding the child's needs, decision making and planning. No cases were escalated as a concern.

## CHILDREN ON CHILD PROTECTION PLANS

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

### EVIDENCE

At the end of March 2023, 181 children were on a CP Plan, a reduction of 211 from 2021/22. This reducing rate continues the trend seen over previous years and at 33 per 10k is well below statistical neighbours (42) and the England average (42). Hackney Children & Families Services accounts for this as follows: Our rate per 10,000 last year was also lower than our rate the previous year. This decrease in the rate is despite a 13% increase in Initial Child Protection Conferences, with 301 held in 2022/23 compared to 267 in 2021/22. There was a 5% increase in children ceasing a Child Protection Plan over the last year, from 267 up to 281. Through the course of the pandemic we saw an increase in some of our longer Child Protection Plans where children were subjects of Care Proceedings and living at home. As these proceedings have concluded, we have seen a decrease in the number of Child Protection Plans. London neighbouring boroughs are reporting a similar reduction in Child Protection numbers, as families are also moving out of London due to cost of housing and cost of living crisis, evidenced through the closure/merging of schools across London due to falling pupil numbers. (HCFS Annual Report 2022/23)

# Children in Care

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

### EVIDENCE

As of 31st March 2023, Hackney was responsible for looking after 392 children and young people. There has been a significant decrease in the number of children who are in care from a peak of 477 children (75 per 10k) in November 2020 (Hackney CFS believe the high numbers were a direct result of family stressors arising because of Covid-19 lockdowns). The March 2023 rate (65 per 10k) is below the statistical neighbour average (71 per 10k).

### EVIDENCE

*30% of our looked after children are aged 16 and 17; we continue to have a high proportion of adolescents coming into care. Analysis indicates that these children have a family history of trauma, educational exclusion, extra-familial risk and have significant risk factors for adolescents on the edge of care (with Black Caribbean and African backgrounds strongly over-represented). This analysis is informing the development of our Edge of Care strategy. Levels of children accommodated under Section 20 continue to fall. More work is required through the Edge of Care strategy to try and support children to safely return home to parents or family from care, whether they are in care short or long-term.*

(HCFS Annual Report 2022/23)

## PLACEMENT STABILITY, TYPE & LOCATION

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

### IMPACT

*There are some indications that a renewed commitment to a foster-first approach is achieving good outcomes for our looked after children and care leavers with 74% of looked after children in foster care arrangements as at the end of March 2023, which is in line with 75% at the end of March 2022. 28 children (7%) were living in residential homes as at the end of March 2023, a significant decrease from 34 (17%) at the end of March 2022 and down from a high point of 40 children at the end of March 2020.*

(HCFS Annual Report 2022/23)

### EVIDENCE

*The number of children experiencing three or more care arrangements over the course of a year for 2022/23 was 14% which is higher than the statistical neighbour and national averages in 2022/23 of 9% and 10% respectively. As at 30 September 2023, 12% of looked after children had experienced three or more care arrangements in one year. The proportion of children aged under 16 who have been looked after for more than 2.5 years, who have lived in the same home for over 2 years was 64% in 2022/23 compared to 71% in 2021/22. As at 30 September 2023, 69% of looked after children aged under 16 who had been looked after for more than 2.5 years had lived in the same home for over 2 years.*

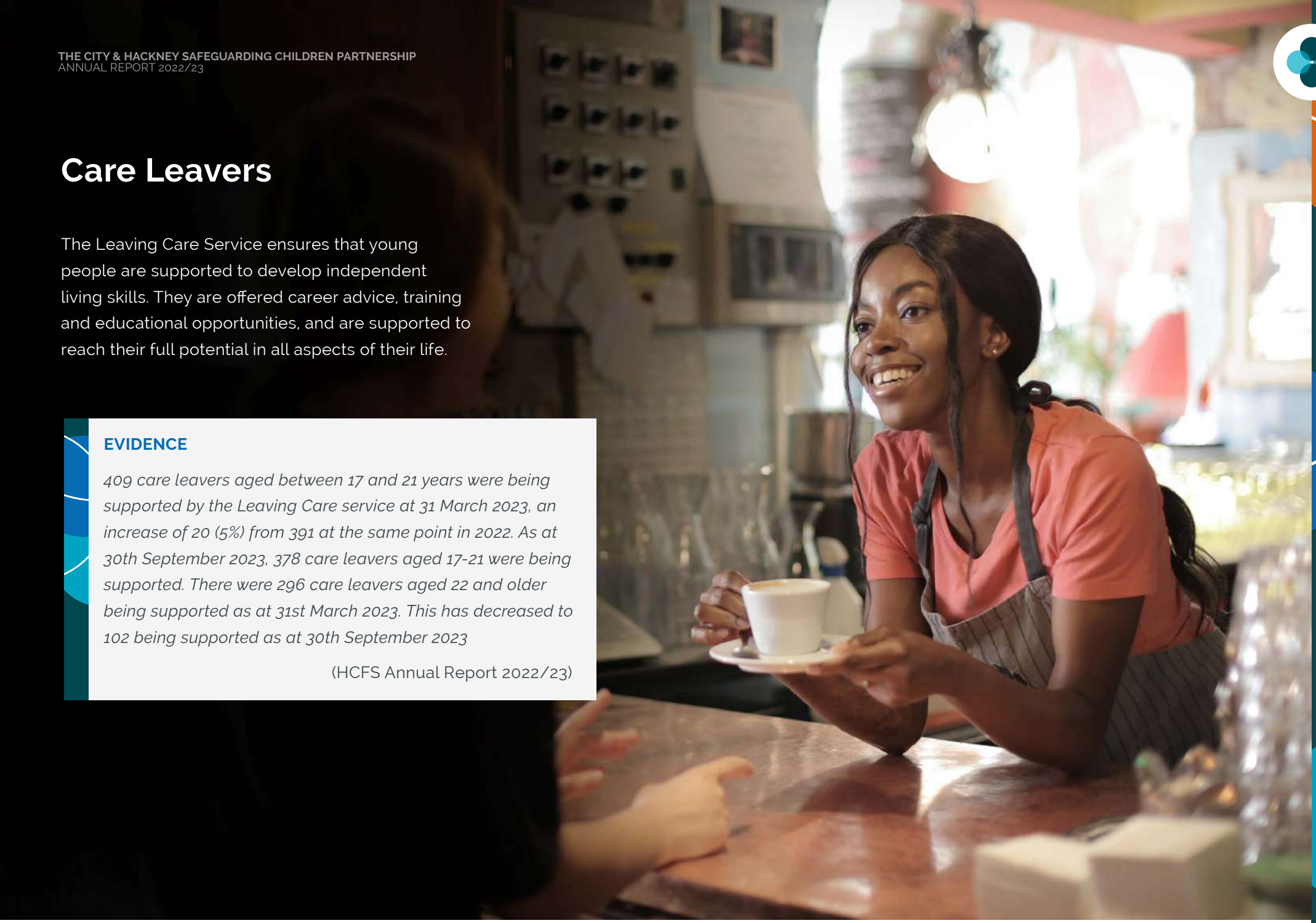
*2020/21 stability figures were particularly good, believed to be influenced by the context of lockdown in the pandemic. However, further analysis has taken place on the cohort of children with 3+ care arrangements and those who have left long term homes to think about what we need to do to strengthen placements; we are working to strengthen our oversight of Independent Fostering Agencies support and training for their carers, we reviewed all connected care arrangements in July 2023 to consider opportunities to strengthen them.*

*We have also taken steps to improve the process of oversight for planning for children once they enter a legal framework and beyond the conclusion of any legal proceedings, again to help ensure that the right decisions are made for children, at the right time. For example through our Permanency Planning Meetings, which are overseen by senior managers, we ensure parallel planning is in place to consider alternative routes to permanency for long-term looked after children.*

(HCFS Annual Report 2022/23)

# Care Leavers

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



## EVIDENCE

*409 care leavers aged between 17 and 21 years were being supported by the Leaving Care service at 31 March 2023, an increase of 20 (5%) from 391 at the same point in 2022. As at 30th September 2023, 378 care leavers aged 17-21 were being supported. There were 296 care leavers aged 22 and older being supported as at 31st March 2023. This has decreased to 102 being supported as at 30th September 2023*

(HCFS Annual Report 2022/23)

# Violence against Women & Girls

It is estimated that 3 in 10 women (aged 16+) will have experienced domestic abuse at some point in their lives and that 1 in 5 children have been exposed to domestic abuse in the home. Responding proactively and in collaboration with the Community Safety Partnership remains a key priority for the CHSCP, recognising both the short and long-term impact on the safety and welfare of children and young people. The CHSCP is represented on Violence Against Women and Girls operational and strategic panels, which is comprised of statutory and voluntary sector organisations. The partnership in Hackney progressed its ambition to move from a strategy based on tackling DV to one that aims at a wider approach responding to all forms of VAWG. This development follows national and regional policy and aims to embrace all forms of violence that are committed against women and girls as they have several commonalities and therefore suggest a linked approach. Operationally, the Domestic Abuse Intervention Service (DAIS) in Hackney encompasses the following areas:

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

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

## EVIDENCE

The average weekly number of referrals into DAIS across 2022/23 was 29 - an increase on 23 in 2021/22. At year end, there were 583 allocated cases in DAIS, with 212 having children.

## IMPACT

During 2022/23 and in 2023/24 DAIS has increased its offer of training to the Hackney partnership and it is believed this, along with campaign work, increase in awareness has led to greater confidence in the public and professionals accessing help for domestic abuse.

## EVIDENCE

With a focus on perpetrator interventions, the Domestic Abuse Prevention Programme, working with those who harm others through their behaviour is a 26-session programme that continues to operate on a rolling basis. During 2022/23, there were 23 participants in the programme. 13 left prior to completion and 7 completed the sessions in full.

# MARAC

The MARAC (Multi Agency Risk Assessment Conference) is a fortnightly multi-agency meeting to discuss and take action on cases of domestic abuse where there is a 'high risk' of death or serious injury. Numbers have continued to rise, and the partnership continues to reflect a robust response to providing multi-agency support to victims and children at risk.

## EVIDENCE

691 cases were heard at MARAC in 2022/23, consistent with the numbers heard the previous year (694) Around half of all MARAC cases (327) have children living in the household; this has remained consistent over recent years. 166 were repeat cases heard at MARAC. Domestic Violence and Abuse remains one of the key issues impacting upon the safety and welfare of Hackney's children.

# Safeguarding Adolescents

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

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

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

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

## ASSURANCE

*In March 2023, in response to a locally commissioned report on serious youth violence, 'Living in Fear', we introduced the process of convening Initial Child Protection Conferences where the risk of significant harm is identified as being solely outside of the family home. Previously these children would be supported primarily through a Child in Need Plan and Initial Child Protection Conferences were held where the risk was identified inside of the family home, or both inside and outside of the family home. These Child Protection Plans are monitored by the Head of Service, and we will be reviewing and monitoring the impact of these plans on children's outcomes.*

(HCFS Annual Report 2022/23)

## LEARNING

The CHSCP undertook a Rapid Review following the fatal stabbing of a young person, Child J. Learning identified from this process is feeding into a refresh of the CHSCP's safeguarding adolescent strategy and action plan. Further details about Child J are included in the Learning & Improvement section of this report.

## CHILD SEXUAL EXPLOITATION

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

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

DfE 2017

### EVIDENCE

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

- CSE risk resulting from peer-on-peer abuse (sexual offences/ exploitation against one or more victims and usually perpetrated in a group setting)
- CSE risk from an adult perpetrator (typically a young person believing themselves to be in a 'relationship' with an adult after being introduced to them by a normally vulnerable friend, or through online contact)
- Exploitation via social media (inciting or encouraging a victim to take and send explicit images of his/herself)

## EVIDENCE

Contacts for 37 children were received where Child Sexual Exploitation had been identified as a potential concern. This represents 0.4% of all children who had contacts received in the year.

75 children had a statutory social work assessment that took place where Child Sexual Exploitation was listed as an Assessment Factor. This represents 1.7% of all children with Child and Family Assessments received in the year.

On 31/03/2023, there were 10 open children to Children and Family Services who had a contact with Child Sexual Exploitation flagged as a concern.

Referrals for CSE are more heavily weighted towards females than with other forms of extra-familial harm.

## ASSURANCE

Redthread is a charity that works alongside young people who have been affected by, or are at risk of, violence and/or exploitation and has been based in ED at Homerton Hospital since July 2018. *Youth workers are embedded within the Emergency Department supporting young people at the bedside and then follow them into the community, for 6 - 12 weeks of work, to ensure they have the wrap-around and long-term support in place. Our Young Women's Service (YWS) at Homerton, which is our only local hospital to have this service in place, launched in July 2021. The YWS is similar to YVIP in that we support young women aged 11 - 24 who have experienced or are at risk of violence, sexual violence and exploitation (both criminal and sexual) and young people who have been impacted or self- identify as 'gang' affected. The key difference is that the service offers a longer-term support of up to a year for young women and self-identifying young women.*

Homerton Healthcare NHS Foundation Trust Annual Report 2022/23

## IMPACT

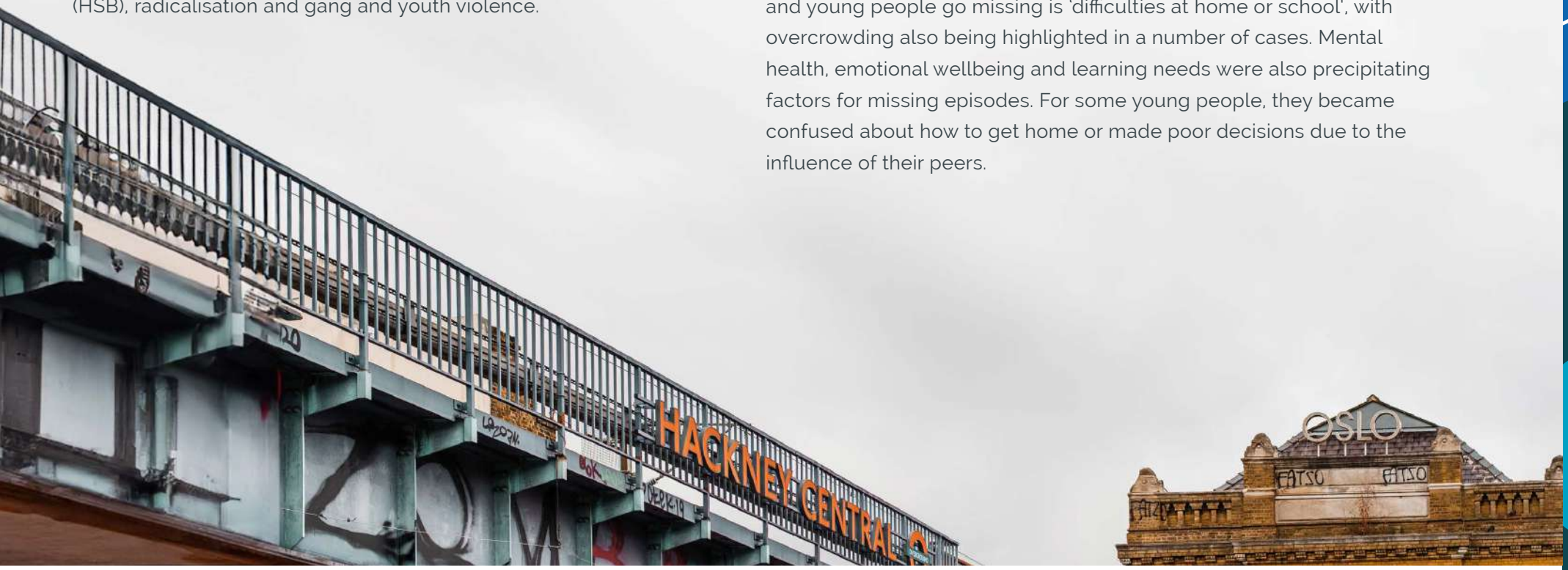
Redthread intervention has demonstrated to be especially beneficial to the young people who engaged with the service. This has been possible thanks to the strong multi-agency collaboration between ED, the SCT and CAMHS.

- 166 total eligible referrals to Redthread
- 111 of eligible young people referred were supported in some capacity by Redthread.
- 103 eligible referrals received for under 18s (66% of eligible referrals)
- 100% of young people felt as safe (64%) or safer (36%) after working with Redthread.

## CHILDREN MISSING FROM HOME, CARE AND EDUCATION

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

When a young person returns from an episode of going missing, they are offered an independent return home (IRH) interview by the Children's Rights Service. The use of Independent Return Home Interviews continues to be effective in supporting young people to share information about push and pull factors, what happens when they go missing and what support they need to reduce further episodes. The implementation of a daily meeting with Missing Police has supported better working relationships, information sharing and development of robust risk assessments and timely plans to locate children and offer the appropriate support. The most prominent reason why children and young people go missing is 'difficulties at home or school', with overcrowding also being highlighted in a number of cases. Mental health, emotional wellbeing and learning needs were also precipitating factors for missing episodes. For some young people, they became confused about how to get home or made poor decisions due to the influence of their peers.



## EVIDENCE

There were 1,301 missing episodes which took place between 01/04/2022 and 31/03/2023.

A total of 265 children were reported missing (an average of 4.9 missing episodes per person)

69% of children reported missing were reported missing from home, and accounted for 28.4% of all missing episodes (an average of 2 missing episodes per person)

37% of children reported missing were looked after at the time of the missing episode and accounted for 71.6% of all missing episodes (an average of 9.5 episodes per person).

In relation to missing children there is less discrepancy in relation to gender, and both males and females are evenly split in being reported as missing. 57% male, 43% female.

## IMPACT

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

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

## EVIDENCE

As of September 2023, there were 356 children electively home educated (EHE) by their parents. A new EHE policy and assessment framework was introduced in June 2020 and is now embedded into practice. New referrals receive a suitability assessment within 12 weeks of referral and an annual assessment. 84% of this current cohort were seen within 12 weeks (a drop from 95% the previous year).

Locally, the majority of children missing education (CME) are from the Orthodox Jewish community, with these children attending unregistered education settings (UES) on a full-time basis, where we are unable to assess the suitability of their education. As of September 2023, there are 1173 registered children missing education (up 365 on 21/22), with 1051 (up 297 on 21/22) from the Orthodox Jewish community. Processes are in place for tracking CME in and out of the borough and steps are taken to visit the known Orthodox Jewish families to check on children's wellbeing, though impact here is more limited.

## GANGS, CRIMINAL EXPLOITATION AND SERIOUS YOUTH VIOLENCE

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

### EVIDENCE

Contacts for 167 children were received by HCFS where Criminal Exploitation had been identified as a potential concern. This represents 1.7% of all children who had contacts received in the year.

145 children had a statutory social work assessment where Criminal Exploitation was listed as an Assessment Factor. This represents 3.2% of all children who had Child and Family Assessments received in the year.

On 31/03/2023, there were 74 children open to HCFS where Child Criminal Exploitation had been flagged as a concern.

Most referrals in relation to Criminal Exploitation relating to either drugs or gangs were in relation to male children from Black and Global Majority backgrounds.

### EVIDENCE

Contacts for 185 children were received by HCFS where Serious Youth Violence and Weapons had been identified as a potential concern. This represents 1.9% of all children with contacts received in the year.

13 children had a statutory social work assessment that took place that had Serious Youth Violence and Weapons related assessment factors. This represents 0.3% of all children with Child and Family Assessments received in the year.

On 31/03/2023, there were 70 open children to Children and Family Services who had a contact with Serious Youth Violence and Weapons flagged as a concern.

## EVIDENCE

Local police continue to conduct serious violence threat assessments daily, weekly and monthly to support the tasking process. The tasking process ensures that partnership resources are allocated to undertake interventions in an integrated way. Health services and third sector charities are also playing a key part in the approach to tackling SYV. Red Thread and St. Giles Trust staff are embedded at Homerton University Hospital NHS Foundation Trust (HUHFT) and the Royal London Hospital trauma unit respectively and use 'teachable moments' to divert young people away from offending and violence.

Hackney's Context Intervention Unit and Integrated Gangs Unit are developing closer working relationships with both teams to ensure the partnership is fully sighted on emerging trends and peer groups and locations of harm. Within the Safer Schools Partnership, information is exchanged on a case by case or school by school basis to inform daily and weekly deployments of police, schools and partnership staff. A monthly Gangs Partnership Tasking Meeting is held to present the latest intelligence and analysis on gang youth related violence and exploitation. This meeting identifies priority areas and individuals who require immediate and longer-term partnership interventions.

## IMPACT

As part of a week-long intensification of Operation Sceptre, the MPS ramped up its activity between 14-20 November 2022. A vast range of activity was carried out by officers across London, with officers increasing patrols in violence hotspots, executing warrants to target those known to carry knives and conducting weapons sweeps in areas known for discarded knives. Working closely with the British Transport Police, knife arches were used at transport hubs to deter people from carrying weapons and drugs on trains and the tube. MPS Special Constables and Police Cadets volunteered in their own time to assist regular officers in the operation.

The operation yielded 514 arrests, 995 weapon sweeps, 130 knives recovered and 17 warrants. Furthermore, there were 104 community meetings and educational events, engaging with 949 people; 88 school presentations and engagements, involving 2,466 young people; and 140 retailer visits.

# YOUTH JUSTICE

The Youth Justice Service works with all young people in Hackney who are arrested or convicted of crimes and undertakes youth justice work including bail and remand supervision and supervising young people who have been given community or custodial sentences. Young people are supported by a multi-agency team including a Forensic Psychologist, the Virtual School, Speech and Language Therapists, the Police, a Nurse, Probation Services, a Substance Misuse Worker and a Dealing Officer.

## EVIDENCE

*The overall number of young people entering the youth justice system for the first time in Hackney in 2022/23 was 54, a 19% decrease from 67 young people in 2021/22. This remains below national and statistical neighbour averages. 91% of the young people referred to the Youth Justice Prevention and Diversion Team via Triage in 2021/22 were successfully diverted from becoming first time entrants to the youth justice system in the 12 months that followed (the 2022/23 cohort outcomes will be reported by November 2023). However, early help for young people at risk of becoming involved in crime is still not effective enough at preventing the most serious youth crime: the small number of young people referred to the Prevention and Diversion Team from Triage who have gone on to enter the youth justice system have in some cases faced extremely serious charges against them.*

(HCFS Annual Report 2022/23)

## ASSURANCE

Following a joint inspection in 2022/23 by His Majesty's Inspectorate of Probation, and colleagues from HM Inspectorate of Constabulary, Fire and Rescue, the Care Quality Commission, Ofsted Education and Ofsted Social Care, Hackney Youth Justice was judged to be 'GOOD'. Chief Inspector of Probation Justin Russell said: *"Hackney Youth Justice Service is a strong and passionate team who are determined to do all they can to improve the lives of the children they supervise. This is a service unafraid to tackle the issues children face, not least racism and disproportionate representation, and make positive changes. I look forward to watching them develop further."*

Read the report HERE.

## RADICALISATION

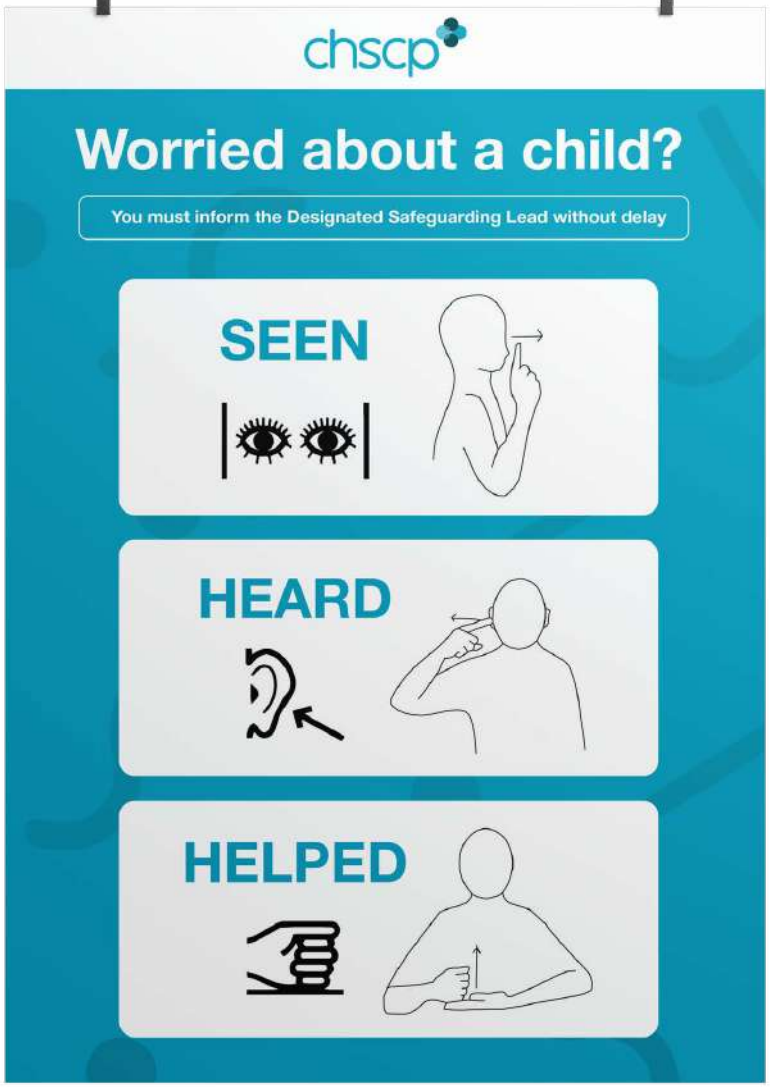
Statutory guidance expects Local Authorities to assess the threat of radicalisation in their areas and to take appropriate action. The Community Safety Partnership (CSP) retains overall governance of this agenda, which includes a focus on ensuring there are sufficient arrangements in place to safeguard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

### EVIDENCE

During 2022/23, there were 35 referrals made to the Prevent Mailbox, an increase from the 26 made in 2021/22. Out of these, 26 referrals were male subjects, and six were female. The largest number of referrals originated from the MPS. 14 involved young people under the age of 18.

# Private Fostering

A child under the age of 16 (under 18, if disabled) who is cared for and provided with accommodation by someone other than a parent, person with parental responsibility or a close relative for 28 days or more is privately fostered. Comparison with national and statistical neighbours has not been undertaken following the DfE ceasing to publish statistics on notifications and closing the private fostering data collection for local authorities. At the end of October 2023, 9 private fostering arrangements were open to Hackney.




# Children with Disabilities

## EVIDENCE

As at the 31 of March 2023, Hackney's Disabled Children's Service was working with 416 children and young people. Of these 143 were female and 273 were male. This is a 5% increase compared to 2021/22, when the service was working with 395 children and young people.

## ASSURANCE

Since April 2021, children receiving care packages who are also on Child in Need Plans in relation to safeguarding concerns have transferred to the Disabled Children's Service. This provides greater consistency and ensures that processes are clearer for families. As at the end of March 2023, there were 14 children on Child in Need Plans, 4 children on Child Protection Plans and 4 looked after children receiving support from the Disabled Children's Service.

# Children's Mental Health

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

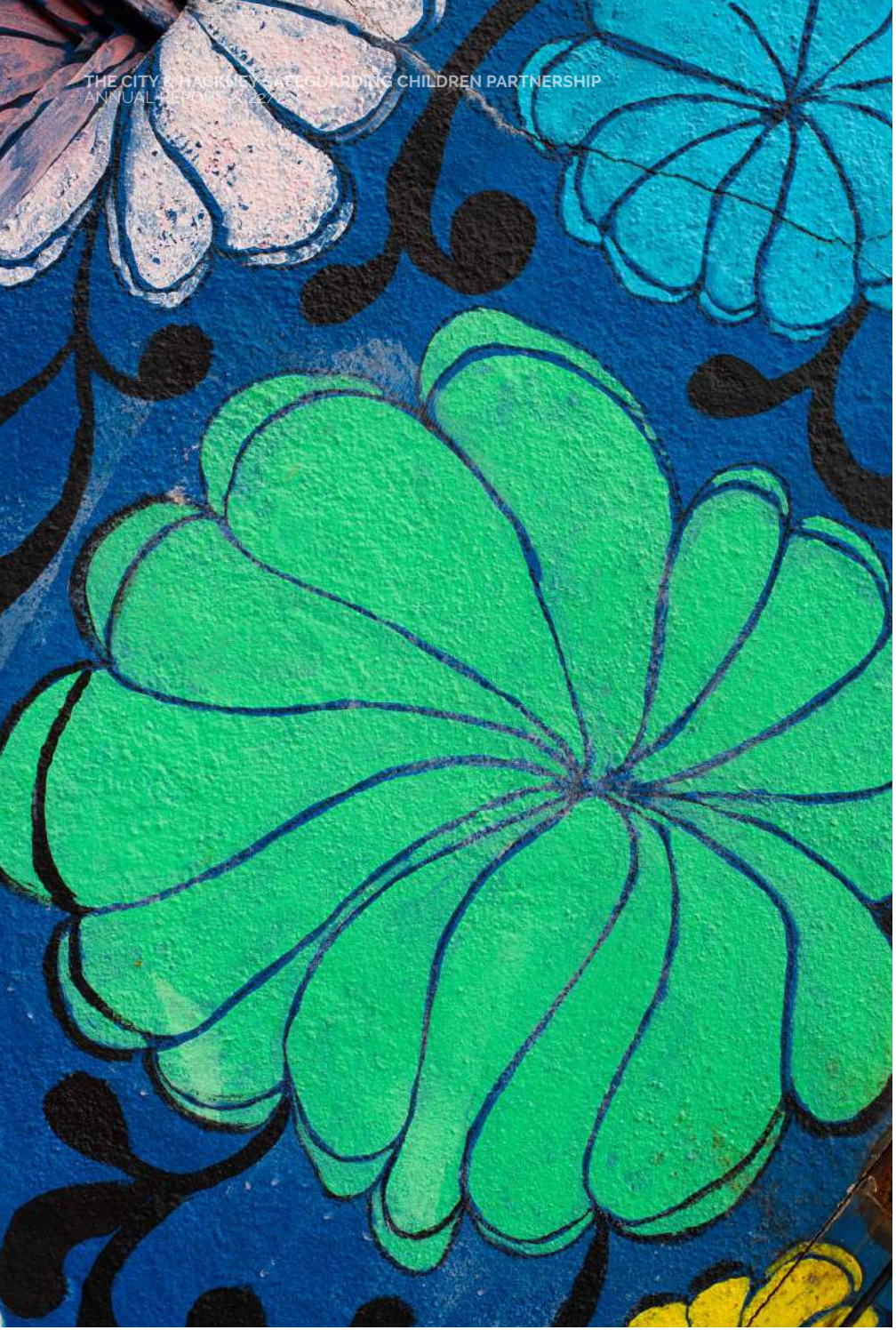
## EVIDENCE

*For the early intervention part of our services, we have initiated a number of wait-list initiatives over the past year and waiting times across First Steps have decreased from the peak of 18 months to 6 months on average across pathways, however this is still higher the pre-COVID wait time of 3 months and this work will continue over the next phase. Our initiatives have included an increased number of workshops available, a trial of face-to-face initial consultations and online guided self-help programmes. We have also increased our uptake of training places for clinical psychologists and CAMHS clinicians to strengthen the capacity of our workforce. Homerton Healthcare.*

NHS Foundation Trust Annual Report 2022/23

## EVIDENCE

Mental health is a flagship priority for the ICS, with a strong provider collaborative established to work with communities and partners in all of our seven places to improve experience, access and outcomes for local people. There has been a sustained focus on expanding and improving mental health services, and services for people with a learning disability and/or autism. We know that Covid-19 has not only affected the delivery of services but has also caused in increase in demand, particularly for talking therapies, children and young people's services, severe mental health and perinatal health. NHS NEL Annual Report 22/23. These challenges as they relate to services for children, young people and families remain subject to scrutiny by the CHSCP through its risk register.



# MAPPA

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

## EVIDENCE

Across London on 31 March 2023, there were 6901 Category 1 'Registered Sex Offenders' (RSOs) (6700 in 2021/22, 6549 in 2020/21, 6581 in 2019/20 and 6452 in 2018/19), 3669 Category 2 'Violent Offenders' (3660 in 2021/22, 3521 in 2020/21, 3735 in 2019/20 and 4128 in 2018/19) and 51 Category 3 'Other Dangerous Offenders' (55 in 2021/22, 61 in 2020/21, 31 in 2019/20 and 27 in 2018/19). 158 RSOs were cautioned or convicted for breach of notification requirements. (153 in 2021/22)

## LEARNING

Whilst scheduled for publication in early 2024, the following extract from the report into Case A provides an insight into the challenges being faced in this area of safeguarding.

*For individuals known to have committed child sex offences, they will always present a risk to children. What this looks like will vary from offender to offender and can change over time, but there will never be no risk at all. Accepting this fact must be the starting point for everyone working with children, their families and offenders themselves. It reflects an unambiguous safeguarding first approach and there should be no practice within our system that dilutes this position. Time served in prison, sex offender courses, dynamic assessment and monitoring can all have the potential to reduce recidivism. However, what they can't do is change the fantasies of those with a deviant sexual interest in children or predict with absolute certainty who will go on to re-offend. It is factors such as these that make the management of child sex offenders so complex and why the paramountcy of child protection must always steer the decision making and actions of practitioners.*

*Beyond this complexity, we also know there continues to be a growth in activity and that resource pressures on public services remain. Combined, these circumstances have created somewhat of a 'perfect storm' that is placing immense strain on those agencies responsible for this work, particularly the police. As highlighted in the independent review by Mick Creedon QPM, because of this environment the system needs to work differently. We agree.*

*However, whilst accepting there are no easy answers, we don't believe that system change should correlate with a system doing less. Many would see this as counter-intuitive, and yet solutions continue to be promoted that focus on a reduction in activity to cope with demand. This has largely, but not exclusively, focused on those perceived as being 'low risk offenders' and/or 'viewers' of indecent images.*

*As far back as 2017, the former child protection lead for the National Police Chief's Council (NPCC) raised concerns about the volume of offending and that the police had reached 'saturation point' in terms of its capacity to respond. He argued there was a need to look at alternatives to custodial*

*sentences, including prevention and rehabilitation, although the monitoring of offenders would continue. More recently, the report by Mick Creedon QPM recommended changing the monitoring regime itself by introducing discretion, reducing timescales and allowing for more flexibility in decision making.*

*All these points can be seen as an understandable response to the demand / resource conundrum that the police are facing. That said, it is hard to see how any of them will make children safer. Tweaking the system will weaken the system and doing less won't address the fundamental challenges in this space. What is perhaps more likely is that additional fault-lines will appear in the form of harm. Based on the lessons from this review, we believe there are opportunities to do more. More by way of harnessing the insights of others to help improve the monitoring of offenders, mitigate risk and increase protection. This can only happen with improved partnership arrangements and information sharing.*

Jim Gamble QPM & Rory McCallum, SPA

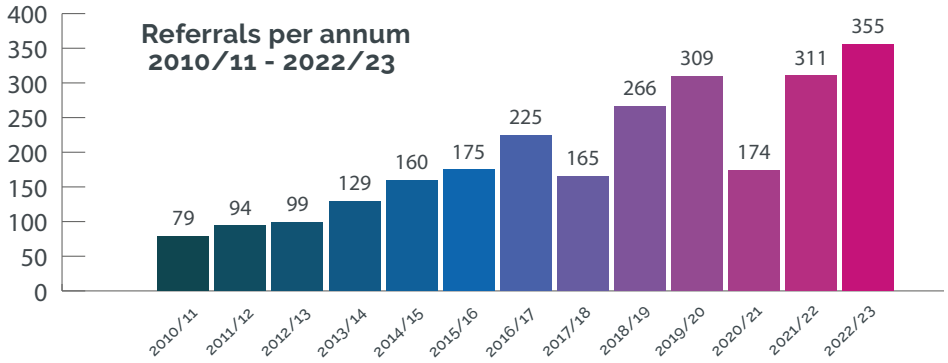
# Safer Workforce

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

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

### EVIDENCE

There were 355 contacts to the LADO in 2022/23, a 12% increase from the 311 contacts in 2021/22. Other than during 2020/21, there remains a year-on-year increase in activity.

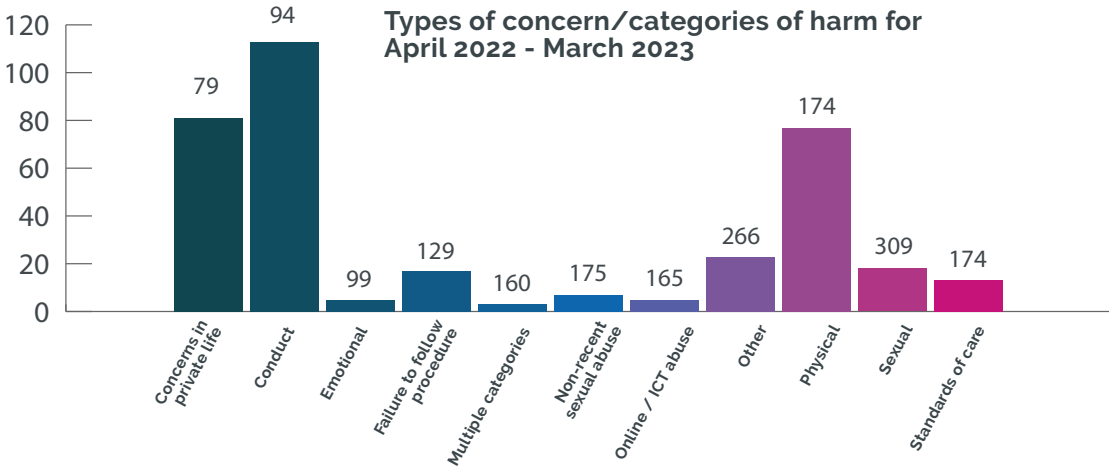



### EVIDENCE

The occupations with the highest number of contacts were school support staff (26%), teachers (26%) and nursery workers (12%). An increase was noted for both school support staff (by 3%) and nursery workers (by 5%) with teachers showing a decrease (by 3%) compared to 2021/22. The three occupation groups with the highest number of contacts remain unchanged.

### EVIDENCE

The highest number of contacts related to concerns about conduct (32%), concerns in private life (23%) and concerns about physical harm (22%). These, as the top three categories, remain unchanged from the previous period, although for the first time, conduct matters were highest.




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.

## EVIDENCE

Consultations were the highest demand for the LADO service in 2022/23 accounting for 77% of contacts, which is in line with the percentage for the previous period (75%). Less ASV meetings took place in 2022/23 (5.9% compared with 10.6% in 2021/22).

## EVIDENCE

*'The majority of cases during 2022/2023 resulted in an 'unsubstantiated' outcome. The fact that the concern/ allegation had not been substantiated for the majority of cases 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. Uncommonly, two cases resulted in a 'false' outcome. The cases that are 'ongoing' refer to awaited outcomes of Police investigations related 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.'*

Hackney LADO Annual Report 2022/23

## LEARNING

**LADO Training & Awareness Raising** - The Hackney Education (HE) Safeguarding in Education Team runs an extensive training programme throughout the year including Safeguarding and Child Protection training for Hackney Education staff, Designated Safeguarding Leads for schools, colleges and early years, school and college staff, governors, early years and childminders. Their training covers safe practice and the procedures for dealing with allegations against adults who work with children and young people. They continue to run specific training dealing with managing allegations for managers in the early years and school sector, once every academic year for schools and twice for early years managers. CHSCP training at Level 1 and 3 also covers the management of allegations against staff and volunteers. The LADO services for Hackney and the City of London are now offering joint training on allegations against staff and volunteers. The first training session was held on 24/03/2023 and will be offered bi-annually (spring and autumn).

## ASSURANCE

The responsibility of the LADO is set out in Working Together to Safeguard Children 2018 and Chapter 7 of the London Child Protection Procedures (7th edition). All allegations made against staff, including volunteers, that call into question their suitability to work with or be in a position of trust with children, whether made about events in their private or professional life, need to be formally reported to the LADO. Chapter 7 of the London Child Protection Procedures has recently been amended to provide consistency in respect of the response to low level concerns and to include the wider definition of people in '*Positions of Trust*' (The Police, Crime, Sentencing and Courts Act 2022 has extended the definition of **Position of Trust** within the Sexual Offences Act 2003 section 22A to include anyone who coaches, teaches, trains, supervises or instructs a child under 18, on a regular basis, in a sport or a religion)

## ASSURANCE

In January 2022, the CHSCP Executive discussed the interface between the police and the Local Authority Designated Officer (LADO). This related to the absence of routine contact from the police concerning conduct matters that meet the threshold for the LADO to be notified. This has been an ongoing issue for some time and is not unique to the City of London or Hackney. A Pan-London group looked at solutions, although work was placed on hold due to COVID-19 and subsequently stalled. Given there remained no consistent mechanism allowing for oversight on possible LADO issues concerning the police, the ISCC wrote to Commanders in both the City of London and Hackney seeking their cooperation in this regard. Agreement was reached that the City Police and CE BCU would include a trigger point within their processes to notify the LADO of any case that meets the criteria. However, during the reporting period, only three police referrals had been received by the Hackney LADO.

# 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.

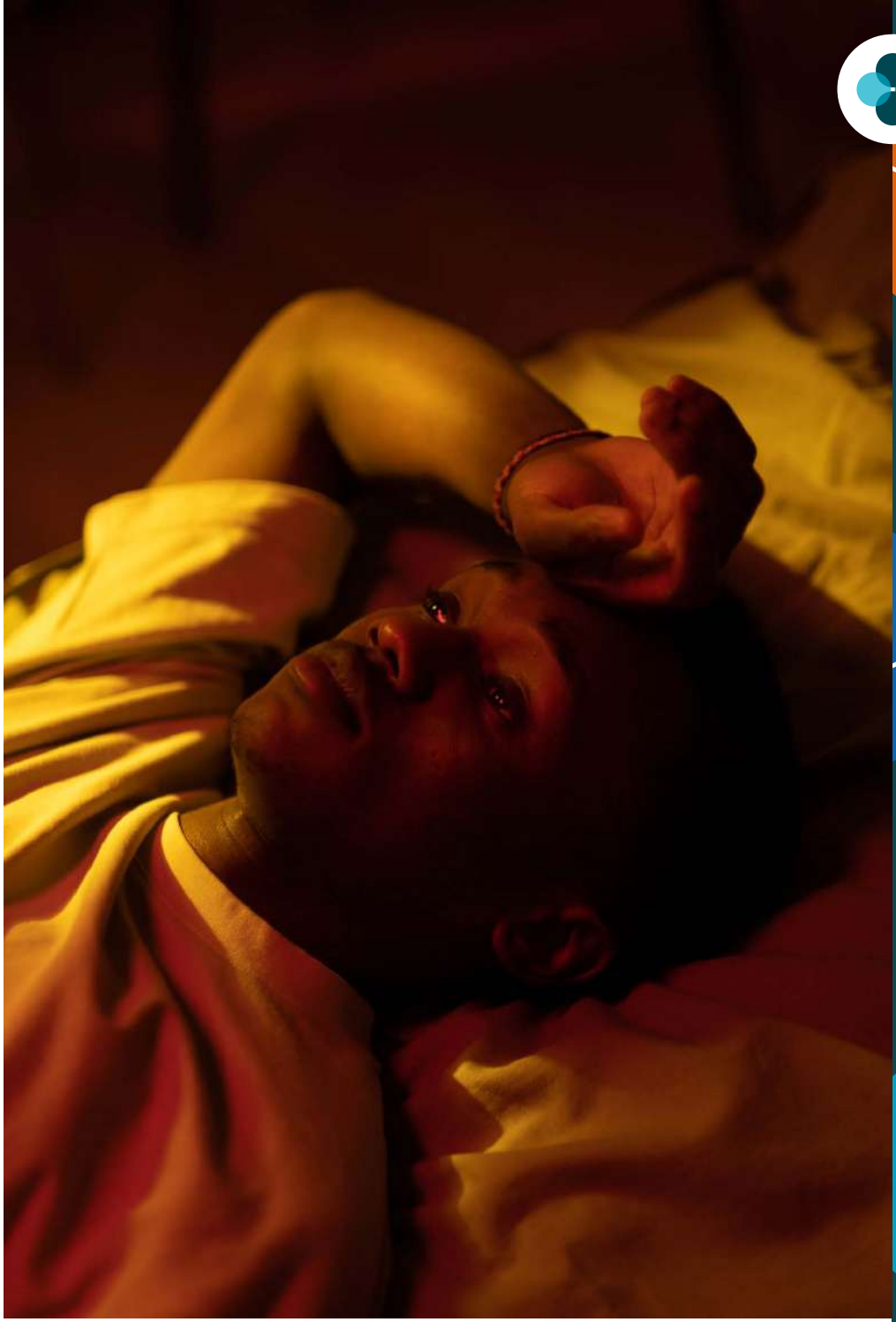
**SUPPORT:** to be provided with support in their own right as well as a member of their family.

**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 to be both professionally curious and confident in challenging the decisions and actions of others. Where disagreement remains, concerns should always be escalated for resolution. To help, the CHSCP has issued a simple Escalation 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 voice 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 us 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 Working Together 2018: *'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.'*

## ASSURANCE

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

## EVIDENCE

During 2022/23, three serious incident notifications were made by Hackney Council to the Panel, all of which were subject to a Rapid Review by the CHSCP. No serious incident notifications were made by the City of London Corporation.

From the notified cases, two Local Child Safeguarding Practice Reviews were subsequently commissioned.

Three other cases (not meeting the criteria for notification) were also considered by the Case Review Sub-Group during 2022/23. One of these resulted in a Rapid Review, although no reviews were triggered.

Whilst no reviews were published during the period, substantial activity was undertaken in preparing for the Child Q update report.

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

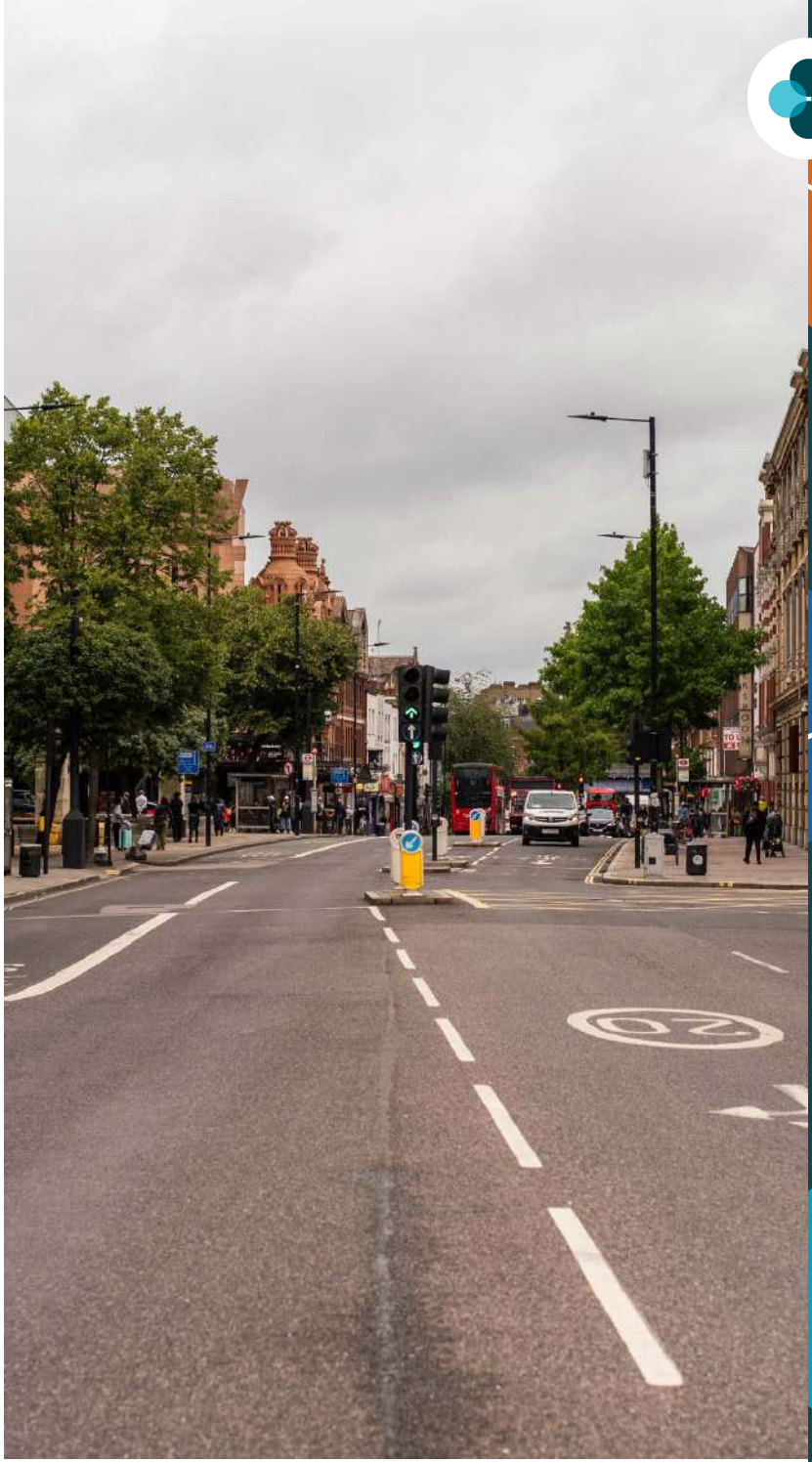
# Rapid Reviews

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.

Four Rapid Reviews were undertaken in 2022-23.



## RAPID REVIEW - YOUNG PERSON J

Fifteen-year-old J was attacked and fatally injured in a park in August 2022. He approached police officers in the area, telling them he had been stabbed. Soon afterwards he collapsed, and officers identified a large wound to the right side of his chest. Assistance from the London Ambulance Service (LAS) was immediately requested with the officers performing CPR at the scene. On arrival, LAS medics took over the care of J and he was treated at the scene. J was taken to hospital by ambulance where sadly, he died a short time later.

### LEARNING

- The help and protection nature of early help support should be explained as such to parents/carers when seeking consent.
- Offers of early help support should be timely and where risks escalate, timely request for statutory support is also vital.
- Exclusion from mainstream school can potentially heighten the likelihood of greater risk.
- In addressing extra-familial risk it is essential to consider the needs and challenges encountered by young people across various situations, and a collaborative effort involving multiple agencies is crucial for ensuring effective safeguarding.
- Think Family professionals should identify risk from wider family network and significant others connected to a child in particular in multi-generational households.

## ASSURANCE

Following careful consideration, and reference to the relevant guidance set out in Chapter 4 para 15-19 of Working Together to Safeguard Children 2018, the ISCC made the decision not to instigate a review of this case. Safeguarding partners and the Panel fully ratified this decision. By way of rationale, there was no evidence that either the actions or inactions of practitioners resulted in missed opportunities to protect J. The details of this case pointed clearly towards committed practitioners from a range of services who were trying hard to help and protect this young person and there were many examples of good practice. Additionally issues of concern relating to extra-familial harm, exploitation, violence and gangs have previously been subject to considerable scrutiny at both a national and local level. Whilst the circumstances in this case highlighted areas for improvement, the immediate learning and recommendations were responded to via the existing structures of the CHSCP and individual agencies.

## LEARNING

GP Leads from the NEL ICB undertook to provide reassurance around the de-registering process for children from a GP (when and how it takes place) and the process for transferring records.

## IMPACT

There was focused awareness raising with GP safeguarding leads in the City of London and Hackney about not deregistering vulnerable children (even if there is non-engagement). Where this is being considered, cases should be discussed at the UPP meeting (meeting between primary care and HV services) to facilitate handover. If registering elsewhere, children would be automatically deregistered from their previous GP.

The circumstances of this case have fed into the ongoing work and refresh of the Safeguarding Adolescents Strategy.

The London Safeguarding Adolescent Oversight Board, which is part of the London Innovation and Improvement Alliance undertook a project aimed at distilling the learning from rapid reviews over the last 18 months (for young people aged 12-18 where significant harm suffered came from outside their immediate family) into a Lessons for London work programme. This Rapid Review report was submitted to feed into this work programme.

# RAPID REVIEW - 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 (SHPO). 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 similarly put into place alongside a five-year Sexual Offences Prevention Order (SOPO). 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.

## ASSURANCE

This case was presented to the Case Review Sub Group of the CHSCP in September 2022. Having considered the circumstances, actions were agreed for the Hackney Council to formally notify this case to the Panel and for there to be a Rapid Review. This was undertaken in October 2022. A decision was subsequently made by the ISCC to trigger a review. Due to a delay in the submission of documentation and capacity issues, the review was not completed within six months and at the time of writing, remains ongoing. It is scheduled for publication in early 2024. The Panel has been alerted to this delay. The review will examine how local agencies managed and mitigated the risks posed by Mr A to his children, other family members and the wider public.

## CHALLENGE

Further to the ISCC's decision, not all safeguarding partners agreed that the case met the criteria for review. Consistent with the CHSCP's written arrangements, this was subsequently resolved by the ISCC engaging directly with Executive members and further explaining the rationale behind his decision.

# RAPID REVIEW - 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 health and social care practitioners due to long-standing concerns about neglect and Child V's health and wellbeing.

## ASSURANCE

Hackney Council notified the Panel of Child V's death in January 2023. Following a Rapid Review, the ISCC decided to instigate a review. This decision was ratified by safeguarding partners and agreed by the Panel. The review remains ongoing and is due to be published in early 2024. It will seek to answer the following questions:

- Was multi-agency practice sufficient and timely in responding to the risks that Child V faced?
- What factors inhibited engagement with and from this family and how did these influence perceptions of risk?
- What role might Child V's complex health needs and disabilities have played in relation to what appears to be a greater tolerance of the parents' actions?
- Was the judicial process sufficient and timely in meeting the needs of Child V and mitigating the ongoing risks that she faced?

## RAPID REVIEW - YOUNG PERSON G

This case relates to a young person with complex needs and autism and the challenges identified in meeting her needs and securing her safety and that of her family. The Police had been called out to the family's address nearly 100 times since March 2021 and there had been numerous hospital admissions.

### ASSURANCE

The MPS identified this as a case for potential learning and submitted a CHSCP 'case for consideration form' to the Case Review Sub-Group in September 2022. An update on the operational issues was also provided in November 2022 and, given the issues of national relevance, an action was agreed to develop and submit a Rapid Review report to the Panel. This was done in January 2023.

### LEARNING

Based on the circumstances facing practitioners, the potential for improvements identified in the Rapid Review were largely outside of the local sphere of influence. All had a nexus with the actions / decisions of central government. For example:

- The impact upon the effectiveness of practice to safeguard children because of the limited placement availability for children.
- The impact upon the effectiveness of practice to safeguard children because of CAMHS resourcing pressures.
- The impact upon the effectiveness of practice to safeguard children because of the parameters governing unregulated / unregistered care provision.

## IMPACT

Correspondence from the Panel in February 2023 noted recognition of these issues at a national level. The Panel acknowledged it would continue to use its influence to raise the profile of these factors with government officials and senior officers. As a follow up locally, an extraordinary meeting of key agencies met in June 2023. This meeting acknowledged that since the original escalation of this case, regular and specialist placements were increasingly difficult to arrange due to a national shortage. Locally, partners acknowledged the usefulness of regular meetings across agencies to discuss available places, to iron out challenges and hold difficult discussions. Autism guidance had also been circulated to the Police and advice provided that discussions on similar cases could be held in the monthly conversations between the Police and HCFS.

Feedback in July 2023 from CAMHS highlighted local factors including depleted staffing (difficulties in recruiting and retaining psychologists). There was also a noted increase in Autism diagnoses that has impacted on capacity to respond - the waiting list for assessment at the time was approaching 18 months. Prior to diagnosis, mental health needs are managed in the wider City and Hackney CAMHS services. An update on the operational issues was also provided in November 2022 and given the issues of national relevance, it was agreed to submit a Rapid Review report to the Panel. This was done in January 2023.

# The Child Q Update Report - Why was it me?

On publication of the initial Child Q review in March 2022, and at the request of Hackney's Mayor, the ISCC committed to providing an independent update on the progress made in response to the review's original 14 recommendations. Co-authored by Jim Gamble QPM and Rory McCallum, Senior Professional Advisor, the Child Q Update report, 'Why was it me?' was released in June 2023.

This report was the culmination of a substantial range of activity undertaken over 2022/23. Setting out 13 new recommendations, it sets out what people have said, provides an independent perspective on the actions of key agencies and evaluates the impact that could be evidenced at the time. The update report can be read HERE.


## ASSURANCE

**Recommendation 1: The Child Safeguarding Practice Review Panel should engage the IOPC with a view to developing national guidance on the IOPC's interface with the Local Child Safeguarding Practice Review process. As a minimum, this should set out the arrangements for securing cooperation, accessing key staff for interview and the requirements for the timely sharing of information.**

Activity in response to this recommendation involved the Panel drafting a new protocol (and information sharing template) and seeking to broker a national agreement on behalf of all safeguarding partners with the IOPC. In addition, the Panel also started to keep track of other serious child safeguarding incidents where joint investigations were taking place, so wider experiences of joint working with the IOPC could inform the work underway. By April 2023, discussions were ongoing about precisely what guidance and supporting documents were needed. At the end of May 2023, the Panel confirmed that agreement had been reached to move forward with the protocol with the aim of having it published later in the summer. The first draft of the protocol was shared with the CHSCP in July 2023.

## CHALLENGE

**Recommendation 1: Whilst positive steps have been taken to develop this protocol, the ISCC remains concerned about its proposals to allow for the sharing of interview records of those engaged in a review with the IOPC. This was set out in a letter to the Chair of the Panel in July 2023 and again, in October 2023. Disappointingly, the Panel has decided against making any changes based on the ISCC suggestions. These are detailed below:**

*"In the Child Q case, the key issue was that those who engaged with us, did so on the understanding that they were participating in a learning exercise. We clearly emphasised this position and the difference between our approach and that of any misconduct or criminal processes at the beginning of each interview. It was on this basis that people ultimately agreed to speak with us.*

*In my opinion, sharing LCSPR interview notes with the IOPC would be inconsistent with Working Together 2018 that sets out the clear distinction between the various processes that can arise from a serious child safeguarding case. I would be concerned that having this as a defined requirement runs the risk of practitioners being less than open during a LCSPR (if they know that whatever they say will be passed onto those investigating matters of misconduct). Whilst noting the protocol includes the need to explain the sharing of notes, I am concerned that in future reviews, we may find that practitioners are less likely to engage with us at all. This would ultimately impact on the ability of safeguarding partners to fulfil their statutory functions.*

*Furthermore, interviewing individuals under different circumstances for different purposes could be found to be an abuse of process. Interviews regarding culpability are usually focused on conduct and accountability and generally take place under 'caution', those carried out to reflect, learn and improve practice (sometimes in groups and generally more discursive) are very different. Other than if there was an admission of a criminal offence or identified safeguarding issue, there should be no expectation that notes/statements gathered for the LCSPR should be used for any other purpose.*

*During our engagement with the IOPC (as part of the Child Q review), the key problem we faced was having access to the officers involved. We were told at the outset that the likelihood of these officers meeting with us was remote, and that the Police Federation would likely advise the officers not to do so. This was understandable given the conduct investigation they were facing and the risk of prejudicing their position if interviewed by ourselves.*

*In response, the IOPC made the CHSCP an 'interested party' – this facilitated the sharing of the IOPC's interview notes with ourselves. Whilst speaking to them would have been ideal, this was the best option available and allowed the review to be completed.*

*At the time, we were clear with the IOPC that we wouldn't reciprocate and share our own interview notes. The IOPC could simply approach those who they needed to speak to as part of its investigation into conduct. We have made the same point to the Teaching Regulation Agency. Whilst acknowledging this may appear to be a 'one-way' agreement, the benefits for LSCPs is the ability to gain an account from police officers who are unlikely to be interviewed. For the IOPC, this ultimately saves a degree of time.*

*I don't dispute the complexity involved here, but my strong advice would be to reword this section to describe the sharing of interview notes being agreed where LSCPs have been unable to access the police officers under investigation and for this to be achieved through the designation of the LSCP as an interested party. I think it would be reasonable for LSCPs to share the details of those interviewed with the IOPC so it can make a determination as to who it might want to approach."*

- Jim Gamble QPM

## ASSURANCE

**Recommendation 2: The MPS should review and revise its recording system for stop and search to ensure it clearly identifies and allows for retrieval of the full range of activity under stop and search powers (including the ability to differentiate between the different types of strip searches undertaken).**

Having acknowledged that the need to publish this data should have been understood much earlier, significant efforts have been made by the MPS over the last year to improve the accuracy of data recording and how this is shared for wider consumption. A thorough review of records indicated double recording of some MTIP searches on the police custody record system and the search record system. Briefings were subsequently provided to all officers, supervisors and the Senior Leadership Team to ensure that data was being captured correctly. Awareness raising, training and regular refreshers about the importance of correct recording continued for all officers, with a particular focus on new joiners and 'street duties' officers. The MPS also released two new dashboards (the Custody Dashboard and the Stops and Search - More Thorough Searches Dashboard) which provide greater granularity, are more user friendly and contain relevant additional data on stop and searches, such as that involving Appropriate Adults. They are a significant improvement on what was available before in the MPS Stop and Search Dashboard. The ability to review data with greater confidence provides more opportunities to identify practice issues, including those that might be linked to disproportionality.

## ASSURANCE

**Recommendation 3: The Department for Education should review and revise its guidance on Searching, Screening and Confiscation (2018) to include more explicit reference to safeguarding and to amend its use of inappropriate language.**

In response to this recommendation, the Department for Education (DfE) worked at pace, recognising the critical importance of incorporating lessons from the Child Q report into its guidance as quickly as possible. An updated version of the DfE's Searching, Screening and Confiscation (2022) guidance was published in July 2022 and implemented in September 2022.

## ASSURANCE

**Recommendation 4: The MPS should update its guidance note and local policy to better emphasise the requirements for engaging an Appropriate Adult under the revised Code C, PACE,1984.**

Update guidance was swiftly issued by the CE BCU prior to publication of the Child Q review. MPS-wide Operational Notices (including relevant practice resources for officers) were created and released on 25 May 2022. This included an immediate policy change requiring an Inspector to authorise any MTIP on a child under 18. 4.33 The MPS stop and search policy was also updated to better reflect PACE Code C, Annexe A, paragraph 11, emphasising the requirement for having an Appropriate Adult present, who would constitute an Appropriate Adult, their role and the recording requirements should one be refused by the child. Reminders continue to be sent locally within the CE BCU and guidance has been made available on the home page of the MPS Intranet.

## IMPACT

**Recommendation 4: Updating and improving the guidance needed to happen and is reported by the MPS as having been welcomed by officers. Previous guidance was insufficiently detailed to mitigate incorrect and poor practice. By way of potential impact, it is important to emphasise that no MTIPS involving children have taken place in Hackney since March 2022.**

London-wide, there has been a 45% reduction from 2021 to 2022.

Furthermore, no MTIP has taken place on a child without the authority of an Inspector. Whilst this would have made no difference for Child Q (given no authorisation was sought), this has been a sensible response from the MPS in terms of strengthening senior management oversight and decision-making. This approach has since been adopted nationally and features as recommended guidance issued by the College of Policing. More recently, the CE BCU has further reinforced these arrangements. MTIPs involving children now require Superintendent authorisation and those undertaken 'out of hours', must be approved by the CE BCU Commander.

Part of the explicit orders given by Inspectors are that the age of the person being searched is verified and if required, an Appropriate Adult is present. The MPS report that this has resulted in more Appropriate Adults being part of the process and children receiving the protection they are entitled to. In 2020, 29% of MTIPs involving children across London did not have an Appropriate Adult present. In 2021, this had increased to 32%. From April 2022 to March 2023, this figure had reduced to 20%.

## ASSURANCE

**Recommendation 5: The CHSCP should review and revise its awareness raising and training content to ensure the Child Q case is referenced, with a specific focus on reinforcing the responsibilities of practitioners to advocate for and on behalf of the children they are working with / who are in their care.**

The CHSCP and its partner agencies have all been engaged in significant awareness raising and training activity during 2022/23. The core safeguarding training programme delivered by the CHSCP routinely reinforces the lessons from Child Q. Furthermore, there is ongoing communication through the CHSCP's monthly briefings and external trainers have been directly appraised of the Child Q findings for inclusion in any courses as necessary. The CHSCP's Basic Safeguarding Awareness and Training for Designated Safeguarding Leads routinely promotes the need for professionals to apply the principles of Safeguarding First, Context, Curiosity and

## ASSURANCE

**Recommendation 6: Relevant police guidance (both local and national) governing the policy on strip searching children should clearly define a need to focus on the safeguarding needs of children and follow up actions that need to be considered by way of helping and protecting children at potential risk.**

MPS policy was reviewed and updated to align with best practice and to ensure that the impact upon children is routinely considered whenever they are searched. As part of these revisions, the MPS introduced a mandatory process that involves the completion of a Merlin and safeguarding referral for each child subject to an MTIP. Systems have been put in place to monitor and measure outcomes, so that the difference made to children and their families can be monitored and reported upon.

## ASSURANCE

**Recommendation 7: The Central East BCU should engage the local stop and search monitoring group, ACCOUNT, and other representative bodies to consider the lessons from this review and how the effectiveness of safeguarding (as part of stop and search practice) can be overseen through their respective activities.**

Progress has been variable. In some areas, working relationships have been established between the local police and other organisations such as Hackney CVS and the Crib Youth Project. Both are part of the current Community Monitoring Group (CMG) (whilst awaiting a new pilot for this forum). The Wickers is another organisation that has engaged in dialogue with the police and has shown an active interest in joining the CMG. In respect of this specific recommendation, working relationships between the police and ACCOUNT have been harder to establish. The reasons for this are both acknowledged and understood. At a meeting with ACCOUNT members (following the publication of the Child Q report), many expressed continuing distrust with the police, frustration that they were 'meeting but not engaging' and that there was a general lack of transparency and respect given ACCOUNT's lack of access to senior leaders. Views were also expressed that different community groups were being 'played off' against each other by the police. In the context of Child Q's experiences, there was also understandable anger and a belief that the police simply didn't understand the issues, or the effects that the actions of its officers were having on communities in the long run. At a local level, it is this inherent lack of trust that the CE BCU need to prioritise if meaningful engagement is ever to be achieved. There are no quick fixes to this. On a positive note, green shoots are emerging. With new leadership at the CE BCU, its Commander and senior staff are making efforts to connect with key stakeholders with an interest in how the police operate locally.

## ASSURANCE

**Recommendation 8: Where any suspicion of harm arises by way of concerns for potential or actual substance misuse, a safeguarding response is paramount. Practitioners should always contact Children's Social Care to make a referral or seek further advice in such circumstances.**

The CHSCP continues to routinely promote the Young Hackney Substance Misuse Service and the Hackney Child Wellbeing Framework which is a key tool to help professionals understand the safeguarding action needed when there is a concern for potential or actual substance misuse. Hackney Education has issued supplementary guidance to reinforce advice on this issue. A pilot has also been developed between Hackney Children's Social Care and the police aiming for all children who come to the notice of the police for substance misuse concerns (as part of a stop and search) to be referred to Hackney's Multi-Agency Safeguarding Hub (MASH).

## ASSURANCE

**Recommendation 9: The MPS should engage The College of Policing to explore potential improvements to the guidance concerning reasonable grounds involving stop and search activity with children.**

The NPCC and College of Policing have worked together to revise and strengthen the available guidance for police officers to help them make good and consistent judgements about what might constitute reasonable grounds to search a child. Whilst determining what is reasonable or not will always attract a degree of subjectivity, mitigations by way of increasing the minimum authority levels for MTIPs should help improve the consistency of decision making. The CHSCP has further recommended that where, in the exceptional circumstances, police officers have reasonable grounds to undertake an MTIP search of a child, they should consider arresting the child and conducting the search in a police station. This will ensure supervision takes place, authorisation is confirmed, an appropriate adult or parent / carer is present and monitoring of the process is strictly applied.

## ASSURANCE

**Recommendation 10: Alongside Recommendation 3, the Department for Education should review and revise its guidance on Searching, Screening and Confiscation (2018) to include much stronger reference to the importance of keeping records and engaging parents as part of best safeguarding practice.**

Specific guidance on record keeping is contained on page 14 of the updated guidance. This sets out a list of what a school should include in their records, such as the reason for the search, who conducted the search and the outcome. Significantly, the DfE has also emphasised the importance of analysing any data collected to help establish whether 'searching is falling disproportionately on any group or groups [and] they should consider whether any actions should be taken to prevent this'. Guidance on informing parents has also been enhanced and is set out on page 15 of the updated guidance. This was absent from the previous version.

## ASSURANCE

**Recommendation 11 The Home Office and the National Police Chiefs Council should seek to strengthen the Revised Code C, PACE 1984 to better define the engagement of parents / carers / guardians when strip searches that involve the exposure of intimate parts of the body are undertaken on children.**

The aim of this recommendation was simply to strengthen the safeguards available to children by way of their parents, carers or guardians being appropriately informed and engaged by the police. This did not happen with Child Q. Disappointingly, at the time of writing the update report, there had been no progress on this matter, with the government choosing to await the outcome of the IOPC's conduct investigation to consider its next steps.

## ASSURANCE

**Recommendation 12 The CHSCP should engage ACCOUNT, Safer Schools Police Officers and other community organisations to develop an awareness raising programme across schools and colleges about stop and search activity by the police.**

The aim of this recommendation was to help educate and empower children to better understand their rights in respect of stop and search activity by the police. Activity included Hackney Education circulating MOPAC's Stop and Search 'Need to Know' guidance to all schools and colleges. Many local schools also include awareness raising around searches as part of their PHSE lessons and a QR code has been developed in partnership between the CE BCU and Hackney Council, which directs children to a range of non-police advice (collated by Young Hackney) that is focused on staying safe, rights awareness and signposting to support.

## ASSURANCE

**Recommendation 13 The CHSCP should continue with its rolling programme of multi-agency adultification training. Participation should be actively focused on practitioners from the police and schools, with the Training, Learning & Development Sub group developing a process to specifically evaluate impact across these sectors.**

Building on the sessions that had already commenced in 2021, the CHSCP commissioned twice the number of sessions over 2022/23. These continued to explore the concept of 'adultification' from both a research and practice perspective, using case studies, small group discussions and serious case review findings to explore how adultification manifests in practice and its potentially life-long impact. Further details can be found in the training section of the Annual Report.

## ASSURANCE

**Recommendation 14 The CHSCP should expedite its work on developing an anti-racist charter and practical guides that support the eradicating of racism, discrimination and injustice across its local safeguarding arrangements.**

Whilst a draft charter was developed, it has yet to be formally agreed. This has not only been caused by some practical issues, but the significant challenges in trying to align a collective position for the numerous agencies for whom the Charter is intended. Many remain in different places in terms of their understanding of racism and acceptance of certain definitions. This is no more evident than through the debate that has arisen following the publication of the Casey's review, and the MPS Commissioner's unwillingness to accept the use of the term 'institutional'. This was used by Baroness Casey to describe the MPS's problems with racism, homophobia and misogyny. It is also linked to feedback on the use of other terminology such as 'Black and Global Majority'. Other agencies, their staff and some of the children we have spoken with do not agree with this as being either an accurate or appropriate definition. These issues require further dialogue to resolve. Whilst this has not prevented the significant activity of many organisations in respect of anti-racist practice, the progress towards agreeing this Charter remains challenging.

# Auditing

## THE CHSCP'S SELF-ASSESSMENT FRAMEWORK

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

Activity across 2022/23 involved preparation and the re-launch of the Self-Assessment Tool across agencies in the City of London and Hackney. This included a review of current standards and inclusion of updated/new standards including the unacceptability of racism, discrimination and inappropriate behaviour.

### ASSURANCE

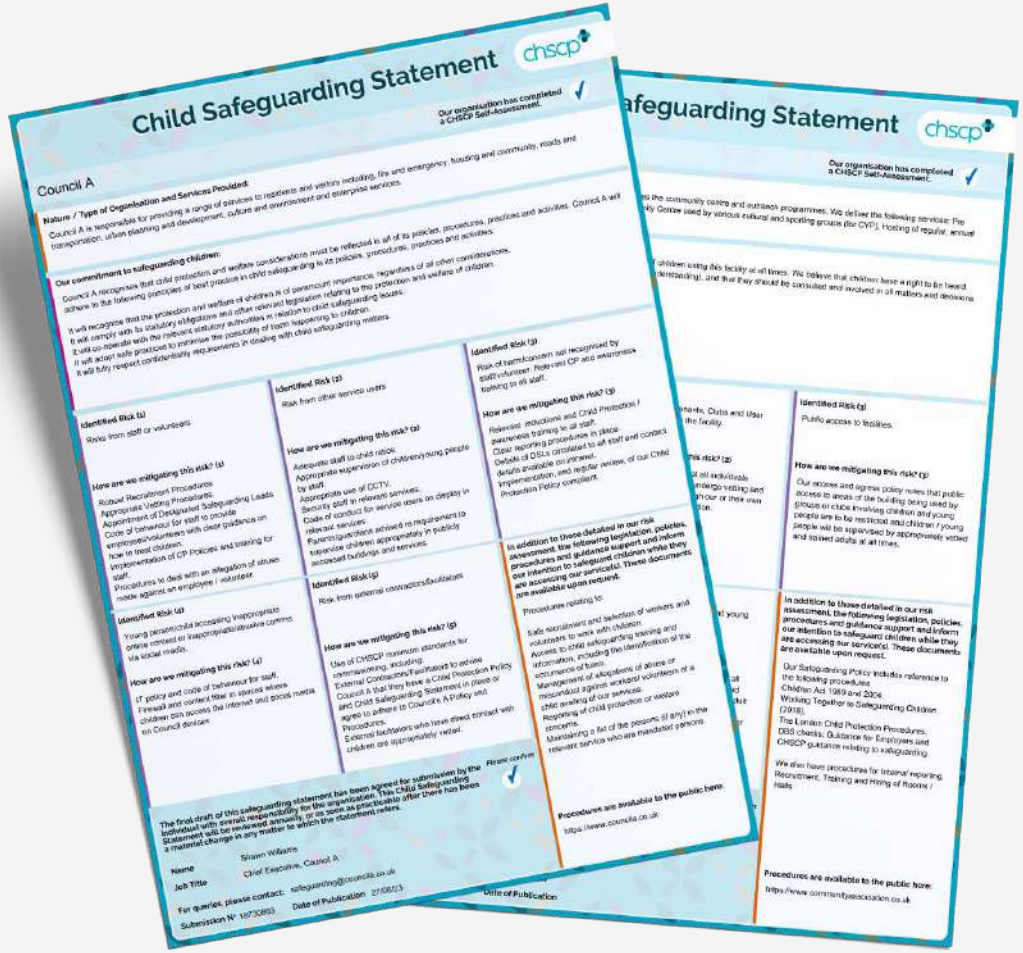
Evaluation of self-assessment returns from the City of London and Hackney provided reassurance about the sufficiency and focus on safeguarding children. There was a generally high response rate of organisations self-assessing as meeting local safeguarding standards. Positively, most standards show either the same (or an increase) in the numbers being fully met. This indicates an awareness of, and the embedding of local standards in organisational practice.

Areas for focus included considering how to consistently engage Out of School Settings and Voluntary & Community Sector Settings about CHSCP training and safeguarding updates and also how to increase engagement by Housing Services (Local Authority and Social Housing Providers). Activity in 2023-24 will include the introduction of Child Safeguarding Statements to support the existing Self-Assessment Framework.

## ASSURANCE

**Child Safeguarding Statements** - In 2022/23, the CHSCP prepared the launch of Child Safeguarding Statements as an additional process to help strengthen leadership and accountability. 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. More information can be found HERE.

A pilot has been undertaken with CHSCP member agencies of the City of London / Hackney Safeguarding Children Partnership Boards. Following feedback, it is proposed that the pilot will engage wider Relevant Agencies and Named Organisations in City and Hackney in 2024/25. A live index of organisations and their completed Child Safeguarding Statements will be hosted on the CHSCP website. 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 was further developed to focus on specific areas of the safeguarding system. This has allowed multi-agency partners to increase the number of auditing rounds and the breadth of scrutiny whilst adapting rapidly to local or national intelligence. This auditing methodology has received excellent feedback from partners and lessons identified have led to tangible improvements. All audits result in an outcome focused 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 2022/23, the CHSCP utilised the in-house expertise of the partnership as well as an externally commissioned service (to provide another level of independent scrutiny). Early in the year, a short delay in the programme occurred due to refocusing the audit theme on the national review into the murders of Arthur Labinjo-Hughes and Star Hobson - Child Protection in England. On publication (in May 2022), it was agreed to evaluate the sufficiency of multi-agency meetings, specifically CIN meetings and Core Groups.

An external audit of CSA was undertaken in Spring 2023, with the findings feeding into a Live Learning Event hosted by HCFS. CSA will be a focus of a multi-agency case audit and full findings will be shared in next year's annual report.

### ASSURANCE

Focusing on the CHSCP's priority to be actively anti-racist, the QA Sub-Group ensured that audited cases were sufficiently reflective of the local demographics and ethnicities of local children and families. The audit tool was also strengthened to evaluate anti-racist practice as a specific theme. This focus will continue in future rounds. In 2022/23, it was agreed to disseminate learning and seek to capture evidence of impact of each audit undertaken in both Hackney and the City of London (regardless of which area the audit cases originated from). This will help build up an evidence bank of shared learning across the partnership.

### ASSURANCE

In June 2023, the ISCC wrote an open letter to all staff emphasising the importance of multi-agency engagement and strong teamwork - Together Everyone Achieves More (TEAM). Acknowledging the lessons arising from the Child Protection in England report by the national panel and the CHSCP's local audits, this letter set out a range of minimum expectations based on established procedure and both national and local learning. Read the letter HERE.

## EVIDENCE & LEARNING

The audit of multi-agency meetings demonstrated that:

- Whilst attendance at multi-agency meetings was generally good, some agencies were not being routinely engaged. Identified areas for improvement related to the scheduling of meetings, where invitations were being sent and how opportunities to facilitate attendance could be enhanced. The audits also identified the need for all practitioners to have access to available support following their attendance at these often-challenging meetings.
- Professionals are proactively sharing information and updates during and between multi-agency meetings. Identified areas for improvement related to the sharing of reports with families, the sharing of minutes and ensuring that information requests made by Children's Social Care to other agencies were clear in explaining the reasons why such a request was being made.
- There was inconsistency in how meetings were being recorded. In examples of good practice, some minutes had woven narratives around the plan into the minutes whilst in other cases, minutes were brief, and it was not possible to discern exactly what information was shared and whether the plan had been discussed in detail at the meeting. Issues were also identified around capacity and skill sets for organising, chairing and minutes of the meetings, which were often undertaken by Local Authority staff. The audits identified the need to review sharing the resourcing for these meetings within the wider partnership.
- Plans were clear and supported good practice. In general they were multi-agency in focus, and it was clear who tasks were allocated to. Areas for improvement were identified around plans being more focused on the outcomes trying to be achieved, ensuring there was a sufficient focus on all children in a family and ensuring actions were explicit for all parents / carers - as opposed to these being heavily weighted towards mothers.
- In Hackney, practitioners were exploring issues around diversity. In the City of London the external audit provided evidence of exploration around issues arising from diversity and this was also evidenced as happening within 1:1 and group supervision sessions. In both local areas, there was good use of interpreters where necessary. The audits identified that support is needed to help professionals explore the impact of racism with the families with whom they work. The CHSCP's Active Anti-Racist Charter is intended to help in this regard and will be released shortly.

- In both Hackney and in the City of London professionals were actively engaging children, young people and family members. Contributions from parents (mostly mothers) were included in the minutes and they were allocated tasks in the plan, along with other members of the network. The audits also demonstrated that the lived experiences of children (where age appropriate) were being explored with children and young people and that the voice of the family was being recorded in meetings. Where appropriate interpreters were used to engage families. A focus on fathers was demonstrated, in particular in Hackney where work with male perpetrators of domestic abuse was featured in plans. Overall, the audits demonstrated that despite some parental non-engagement, practitioners continued to work together and to build bridges with families. The audits identified that children could be better engaged to attend meetings or for advocacy arrangements to be used.

## IMPACT

The audits identified that the correct pathways were being used to invite health professionals to multi-agency meetings.

There had been updates to the City of London Mosaic system to consistently record meeting attendees and recipients of meeting minutes. Internal practice standards have also been set which require the sending of all CIN and Core Group meetings to GP Practices. Administrative resources now facilitate the process of minute taking and distribution to aid consistency.

A City of London Early Help practitioner now attends the multidisciplinary team meeting at the GP Practice.

Findings from the audit have been shared with the Safeguarding Adults Board to support the engagement of adult services, with the audit findings supporting the development of new Think Family guidance.

The audits established reassurance that information requests are sharing the details about why information is being requested and the nature of the concern involving the children.

## SINGLE AGENCY AUDITING

Partner agencies of the CHSCB 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:

### LEARNING

**NEL ICB** - An audit by NEL ICB looking at the quality of GP submissions found that GPs who did not use the templates were more likely to not include medical information about parents. Information was disseminated to GPs about how to locate information sharing proformas and the importance of sharing parental medical information.

### LEARNING

**Metropolitan Police Service** - An MPS audit recognised the need to implement best practice of creating prompt Computer Aided Dispatch Briefings for all unborn children at risk. Controller Inspectors were briefed and up skilled on their significance to ensure an appropriate response to any triggered call for assistance by social workers. Social workers are individually briefed by the Police Conference Liaison Officers to ensure the CAD reference is to hand should they need to trigger any requirement for urgent assistance.

### LEARNING

**Homerton Healthcare NHS Foundation Trust** - Homerton undertook a follow-up audit (first undertaken in 2015) to review the outcome when referrals were made to CSC. Findings indicated a decrease in cases assigned as no further action by CSC. In addition, all cases that were selected were discussed at the weekly paediatric psychosocial meeting demonstrating that when safeguarding concerns are identified by Homerton staff that the children and young people are discussed in a multi-professional meeting to ensure that all follow up is completed. There was also improvement noted by all services completing referrals by the health professional who identified the safeguarding concern. Staff on the acute site have been able to complete referrals on Electronic Patient Record since 2018 which has improved the timeliness of the referrals being made.

## EVIDENCE

**Hackney Children and Families Services (HCFS)** - As part of its Quality Assurance Framework, HCFS undertakes regular thematic auditing of cases. In 2022-23, outcomes were as follows:

- Care leaver parents (June 2022): 40% of audits were rated as good and 52% rated as requires improvement.
- Domestic abuse (December 2022): 55% of audits were rated as good and 39% rated as requires improvement.
- Sexual harm (March 2023): 67% of audits were rated as good or outstanding and 26% rated as requires improvement.
- Life story audit - November 2022: 67% of these audits rated good or better for overall practice.
- Disabled Children's Service looking at children's assessments and plans: 64% rated as good or outstanding.

HCFS also monitors the impact of auditing; three months after an audit has been completed that was scored 'Requires Improvement' or 'Inadequate', a review of the work completed by the auditor is undertaken by Practice Development Managers across HCFS and the findings from the audits are shared with leaders. As a consequence of this monitoring, there has been an increase in the percentage of files improving in ratings of good practice (59% of dip sampled cases showed improvement in April 2023 compared with 65% in June 2023).

## IMPACT

**The City of London Corporation** - As part of its Quality Assurance Framework, the City of London undertakes a quarterly independent audit of cases open to the Children's Social Care team. One of the audits focussed on the impact of social work practice on the children and families they worked with. The findings included that:

*"...the quality of relationships between practitioners, children, young people and families continues to be of a high quality with pieces of excellent practice identified in many of the cases".*

*"Assessment and planning were found to be thorough, regularly reviewed and child centred. Plans would be strengthened by ensuring that outcomes are specific to the child and not a service, by being specific about who is responsible for delivering actions in the plan and particularly where a parent is required to complete an action, so they are clear about the local authority's expectations."*

An area for development was identified as being that *"Social workers shared that they felt supported by their managers, however this was not evident on files where supervision records had not been uploaded for some time."* The issues identified in the audit were progressed and signed off at a meeting chaired by the Assistant Director of People Directorate.

Out of the 10 cases, one was identified as excellent, eight were good and one case required improvement. Recommendations from these audits were completed within a 6-week timeframe from the completion of the audit.

## EVIDENCE

Following publication of the Serious Case Review for Child A in 2021, it was recommended that health providers undertake an audit of paediatric community and inpatient records to ensure that children accessing health care have been involved in an age-appropriate way at each stage of their care planning, and had their views listened to and considered. A summary of the audit report by Homerton Healthcare is detailed below.

An audit of children's notes randomly selected from specific outpatient clinics was undertaken (chosen based on the assumed complexity of the medical needs of children attending). Reviewers objectively reviewed notes to ascertain if attempts were made to see the child alone, and to determine if the voice of the child had been documented. 81 children's notes were reviewed, with 271 appointments attended. In the hospital setting the voice of the child was well documented in 15% of the notes reviewed compared to 37% of those attending community-based appointments. The cohort of children selected had known communication difficulties, 12% of patients seen at the hospital and 75% in the community, which will have impacted on the ability of practitioners to document their voice. This audit highlighted that there is no consistent method of capturing a child's voice in health care settings. Despite education regarding the importance of capturing the child's views about their health care, this continues to be poorly documented in health records. The nature of medical records however means that it is extremely difficult to determine the extent of the child's input into conversations held when reviewing notes at a later date. Changing the way the consultation is documented may help with this. Capturing the voice of the child is significantly harder for non-verbal children and further education and support needs to be given to all health practitioners working with children to ensure that every child's voice is heard.

Audit recommendations include:

- Training on how to capture the voice of the child for all health practitioners, focusing especially on non-verbal children. This could be provided in a variety of formats to make it accessible.
- Changes to documentation standardly used in the emergency department, paediatric wards and outpatients if required to clearly identify the adults accompanying the child, whether the child is seen alone, and if not the reasons for this, and to clearly document the child's participation in the consultation.
- Paediatric consultants and trainees to be encouraged to attend the RCPCH training on fabricated illness.

Results of the audit were also shared with paediatric staff to encourage better documentation of the voice of the child.

# The Voice of the Child, Family & Community

### EVIDENCE

As part of the engagement activity feeding into the Child Q Update Report, the Independent Child Safeguarding Commissioner engaged with over 100 children and young people and parents, carers and members of the community. Their authentic voices were invaluable in helping to develop the report's additional findings and recommendations.

### EVIDENCE

Homerton University Hospital NHS Foundation Trust uses a range of mechanisms to capture the feedback of service users which includes, but is not limited to, electronic surveys, the Friends and Family Test and complaints. Information is collected through hand held devices or electronic survey links are sent to the parents. The impact of the pandemic and the reduction in face-to-face contact with children and families impacted on collecting service user

## EVIDENCE

ELFT CAMHS has strong People Participation work and they run a group with young people, families and carers several times a year. ELFT has a dedicated people participation lead for East London and as part of its recruitment processes, service users are included on the recruitment panels for staff. Service users are encouraged to prepare their own questions for candidates, based on their own experiences of the care they have received from CAMHS. As part of the feedback, the young people recommended that the advert focus less on the processes involved in the job and more on the impact doing this job will have on young people. The feedback was used by the panel to improve the advert.

In one-to-one conversations, participation groups and online surveys, feedback was also sought about the service user experience of the assessment process.

Feedback indicated that service users were unclear about many aspects of CAMHS. Amongst a range of issues, this included how cases are assessed and prioritised, the expected length of waiting times, available support and how best to prepare for assessments.

To drive forward improvements in communications, a working group was formed involving young people and parents. Areas for improvement were identified as making videos (to explain what to expect at certain points), diagrams / maps / flow charts as visual aids, improved webpages, improved letters, text updates, pathway leaflets, new noticeboard displays, and waiting room TV displays.

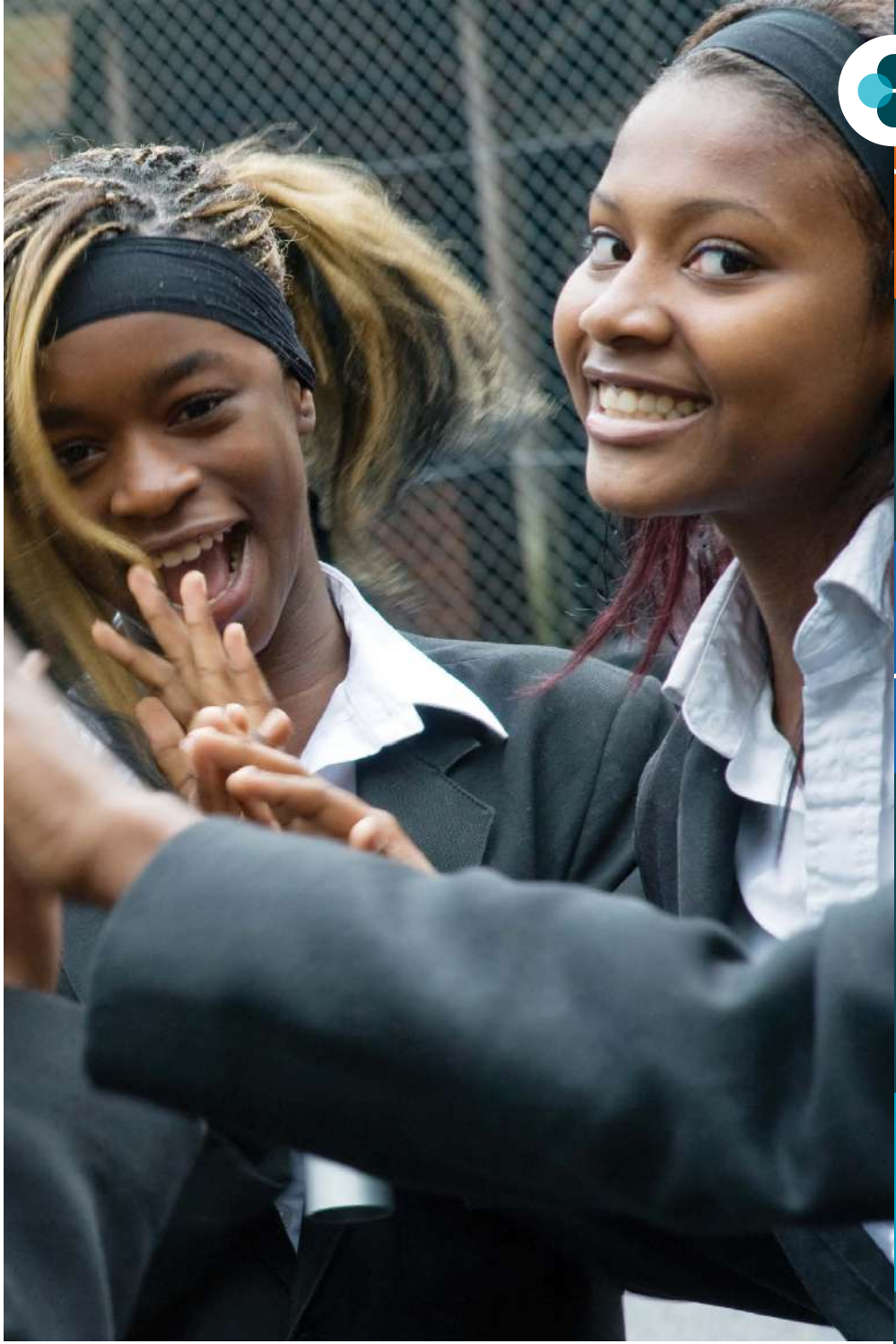
## EVIDENCE

The NEL ICB System Influencers Programme aims to:

- Increase the voice of young people to directly inform how services are designed and delivered
- Increase Health and Social Care professional understanding of the barriers faced by young people
- Help young people  feel more valued and gain confidence, experience and qualifications, which lead to better outcomes.
- Create more opportunities for local young people to become part of the City and Hackney workforce.

System Projects which young people worked on included:

- Data analysis in Quality Improvement Programme, Homerton Hospital
- Marketing and Communications in Quality Improvement Programme, Homerton Hospital
- Physical Activity and Healthy Weight in CYP, Public Health, and
- CYP Community Navigation Project, Neighbourhoods



## EVIDENCE

The City of London Corporation commissions Action for Children to complete an annual survey of all the children and young people open to the Children's Social Care Team and Early Help Service. This survey is completed by someone independent from the city, and the information is anonymous, so children and young people can speak freely. This survey is shared across the organisation, with partner agencies and Members, so that any learning from this survey can be acted on. The 7th annual survey was undertaken in 2022-23. A summary of feedback developed by City of London notes:

- Feedback in general remained positive: there were clear strengths identified by service users, particularly in Early Help and Children in Need, where overall satisfaction of families increased to 66% from 53% in the previous year; and 100% of these families feel included in the development of their Child in Need Plan and its review and believe that this has been explained to them adequately.
- The strength of relationships for children in care was notable: 100% of children in care spoken with said they were able to contact their social workers. Children in care also unanimously felt safe where they are living, and happy with the support they received from a range of professionals, including the Independent Reviewing Officer, participation worker and Virtual School.
- The largest cohort of survey participants were care leavers: 91% felt 'comfortable and easy' to contact their worker, 83% felt that they see their worker at an appropriate frequency, 81% of care leavers were happy with where they live, and 75% felt that the education they accessed was good or very good, an increase from 59% in the previous year.
- Common themes of concern in relation to accommodation issues were noted as: lack of space, awaiting permanent accommodation; location of available accommodation options, and social isolation due to this. Moving through services, and workers leaving were also areas that some respondents found difficult, particularly those who have been involved with services for many years. There was also feedback around lack of clarity in relation to some processes and how services worked together, specifically in relation to children with Special Educational Needs and the Education, Health and Care Plan process.
- Feedback will take the form of a 'You Said, We Did' response to the survey, which can be circulated in written format and via an online template.
- A longitudinal review by the Head of Safeguarding and Quality Assurance will also be undertaken to assess the impact of the surveys on service delivery over time and ascertain how this has changed the experiences and feedback of those working with Children's Social Care and Early Help.

## EVIDENCE

Feedback received by Hackney Council from children and families has included:

**Clinical Service Team** - In 2022/23, a Liaison and Diversion participation group was run over 8 weeks with 10 young people. The young people gave feedback on their experiences with CAMHS and the Police:

- They would like to re-name the clinical service to be called 'Mental health protection and prevention service'.
- They would like there to be more young black clinicians available, safe places to see meet where they feel welcome, and to have food provided. Young people also expressed they needed workers to give them time alone when needed and breaks between sessions.
- Feedback on the 'ideal police officer' was varied, with comments including: someone who is young, understanding and respectful of boundaries; someone that has time, is non-judgemental, and asks 'how do you want to be helped?'; and someone who is able to make a change is older and has experience.

**An Open Letter to Hackney Council** - In October 2022, Hackney of Tomorrow (the Children in Care Council) members wrote an open letter to Hackney's Corporate Parenting Service outlining their view of what it is to be a Corporate Parent and how Hackney Council can best live up to this role. The letter was sent to Service Managers within Hackney's Corporate Parenting Service, as well as Local Councillors and was discussed at Hackney's Corporate Parenting Board and incorporated into the Council's 2023/25 Corporate Parenting Strategy. This autumn, HCFS recruited two new Care Leavers Ambassador posts, to support the work of HoT and to become full-time members of the Corporate Parenting Board, to represent the voice of care leavers.

**Support from Children's Rights Officers** - There were three responses received between April 2022 and December 2022. Overall, children felt positive about the support they received from their Children's Rights Officer (CRO).

- In response to the question 'How did your CRO help you?', 1 person felt their CRO helped them to share their views, 1 person felt their CRO helped them by attending meetings with them, 1 person stated 'other'.
- All 3 felt that their CRO listened to their views, ensured they were involved in decisions that affected them, were treated equally and fairly, understood their situation better since working with their CRO and their CRO helped them to resolve the issues they were unhappy with.
- All 3 felt they knew how to make a complaint about Hackney Children and Families Service.

**Domestic Abuse Intervention Service** - 97% of clients (35) felt positive about the support received from the Domestic Abuse Intervention Service (DAIS). 94% would recommend the service to friends and family who needed help and 86% felt that DAIS took their cultural needs into consideration. 91% felt safer following involvement from DAIS.

**Young Hackney** - A range of feedback has been provided by children, young people and families about the impact that Young Hackney Services have had upon their lives.

*Feedback from a parent: 'Thank you for spending time with [child] over the last few weeks. [Child] has enjoyed talking to you and sharing her thoughts with you. Personally, I want to say thank you for showing up for her and coming when you said you would. It's the little things that mean a lot to her. Also your insight into how we can better communicate and navigate through our emotions were very helpful'.*

*Feedback from a child: 'Our conversations helped me a lot as I was able to understand things in a different perspective. Our little walks around the area were fun, thanks for seeing me for me'.*

*Feedback from a parent: 'I was blown away by the support we received from [Practitioner] from Young Hackney, it was beyond my expectations, and I will always be grateful for the guidance my son, and I received. Not only did [Practitioner] create a great space for the family to be open, but he was quick to grasp the intricacies of the post-separation abuse my family suffers, without judgement. In addition to doing a cracking job in helping [Child] manage his emotions, ([Child]'s mood visibly improved for days after each meeting, which accumulated as the sessions progressed), he provided solid guidance and support for me when dealing with Hackney Children Services. Furthermore, when [Child]'s frustrations flared up recently, [Practitioner] made an appointment to see [Child] without hesitation! [Child] and I wish to thank [Practitioner] and Young Hackney for helping my family through a tricky time. He is truly a 'man of the people'.*

# Performance Data

Activity during 2022/23 focused on the ongoing review of the CHSCP dataset and the development of new dashboards by the CHSCP's Business & Performance Manager. Introduced across Hackney and the City of London, these dashboards provide a much clearer overview of the themes, patterns and trends relating to the key safeguarding metrics. Plans to build on the CHSCP's initial strategic threat assessment have been paused, primarily due to the departure of the fixed-term role that was expected to cover this activity, and a lack of available capacity in the existing team. This will be revisited in 2023/24.

# Front-Line Intelligence

## ASSURANCE

### Staff Survey 2023

For all organisations involved with safeguarding children and young people, staff and volunteers are their most important asset. It is for this reason that the CHSCP has applied a focus upon the health of the workforce since 2017/18. The CHSCP Staff Survey was developed through 2022/23 and issued in February 2023 with several of the questions aimed at triangulating organisational responses from the submitted Self-Assessments and providing reassurance around the CHSCP safeguarding arrangements, the CHSCP's priorities (including Health & Stability of the Safeguarding Workforce) and key practice themes. Given the overall increase in activity across the partnership and the emotional complexity of many safeguarding cases, it is positive to note that in the 2022/23 survey, responses have remained overall positive.

- In total, there were 335 responses received from across the partnership.
- This is a 33% decline in overall response rates since the last Staff Survey in 2018/19.
- Early Years and Education Settings provided the highest number of responses in Hackney.
- Education Settings and Housing provided the highest number of responses in the City of London.

Overall, themes from the Staff Survey provide reassurance about organisations prioritising safeguarding children, access to induction and training, policy and procedures and confidence in practice. Whilst workload was deemed manageable, there were feelings of being at capacity and under pressure to deliver against workloads.

Understandably, concerns were noted around the impact of the cost-of-living crisis, especially the cost of commuting when asked to return to the office. Whilst respondents had been thinking about changing roles, there was an awareness that the cost-of-living impact was a national and not local issue which would not be addressed by moving roles. Respondents felt that organisations should continue raising awareness of support for staff; this could help organisations retain the workforce resulting in stability for service users. A breakdown of the response rates and some of the responses are provided below.

## THE CITY OF LONDON'S WORKFORCE

**52** responses from the City of London. **32** working cross-borough.

**27%** decrease from the last staff survey in 2018/19.

**57%** of respondents from the City of London and **65%** of respondents working cross-borough **work directly with children and young people and families ('direct'). The remainder do not work directly with children and families but will have contact with them ('non-direct').**

**96%** of direct and **91%** of non-direct staff strongly agreed or agreed that their organisation prioritises the safeguarding of children.

**98%** of direct and **79%** of non-direct staff strongly agreed or agreed that they knew who the key safeguarding leads within their organisation were and how to contact them if there is a concern.

**94%** of direct and **49%** of non-direct staff indicated they received an induction that covered safeguarding children when joining their organisation.

**76%** of direct and **85%** of non-direct staff indicated they never or rarely had to cancel or rearrange previously agreed training or development activities due to case work demands.

**92%** of direct and **76%** of non-direct staff strongly agreed or agreed their organisation's child protection / safeguarding policies and procedures are detailed and provide them with step-by step guidance on what to do.

**71%** of direct and **39%** of non-direct staff knew how to access and use the relevant threshold tool (Hackney Child Wellbeing Framework and / or the City of London Thresholds of Need).

**82%** of direct and **79%** of non-direct staff strongly agreed or agreed that they felt confident knowing what to do if they disagreed with another professional about their actions or decisions.

**94%** of direct and **88%** of non-direct staff strongly agreed or agreed that they were confident they would know what to do if concerned about the behaviour of a professional working with or having access to children and young people.

**94%** of direct and **100%** of non-direct staff strongly agreed or agreed that they had a clear understanding of what anti-racism means and what it is to be anti-racist in practice.

**92%** of direct and **97%** of non-direct staff strongly agreed or agreed that they had sufficient understanding and confidence to be able to challenge racism or microaggressions in practice.

**82%** of direct and **94%** of non-direct staff felt their workload was

manageable.

**82%** of direct and **76%** of non-direct staff strongly agreed or agreed that they could raise concerns if their workload was too high, and that action would be taken to support them.

**94%** of direct and **88%** of non-direct staff have access to good quality supervision.

**77%** of direct and **70%** of non-direct staff strongly agreed or agreed that their supervision routinely focuses on helping them to 'think family' and consider the needs of all individuals that they work with directly or with whom they have contact.

**73%** of direct and **82%** of non-direct staff strongly agreed or agreed that their supervision routinely covered whether the children they are working with have been seen and spoken to and agreed actions where this hasn't happened.

**90%** of direct and **58%** of non-direct staff indicated they were alerted to the publication of a CHSCP review by their organisation and made sure they were aware of relevant learning.

**43%** of direct and **18%** of non-direct staff strongly agreed or agreed that the cost-of-Living crisis is negatively impacting upon their effectiveness at work.

**37%** of direct and **30%** of non-direct staff strongly agreed or agreed that they were thinking about changing their job due to the cost-of-living crisis.

## HACKNEY'S WORKFORCE

**251** responses from Hackney. **32** working cross-borough.

**34%** decrease from the last staff survey in 2018/19.

**80%** of respondents from Hackney and **65%** of respondents working cross-borough **work directly with children and young people and families ('direct'). The remainder do not work directly with children and families but will have contact with them ('non-direct').**

**98%** of direct and **98%** of non-direct staff strongly agreed or agreed that their organisation prioritises the safeguarding of children.

**96%** of direct and **94%** of non-direct staff strongly agreed that they knew who the key safeguarding leads within their organisation were and how to contact them if there is a concern.

**97%** of direct and **81%** of non-direct staff indicated they received an induction that covered safeguarding children when joining their organisation.

**72%** of direct and **77%** of non-direct staff indicated they never or rarely had to cancel or re-arrange previously agreed training or development activities due to case work demands.

**96%** of direct and **90%** of non-direct staff strongly agreed or agreed their organisation's child protection / safeguarding policies and procedures are detailed and provide them with step-by step guidance on what to do.

**62%** of direct and **62%** of non-direct staff knew how to access and use the relevant threshold tool (Hackney Child Wellbeing Framework and / or the City of London Thresholds of Need).

**89%** of direct and **89%** of non-direct staff strongly agreed or agreed that they felt confident knowing what to do if they disagreed with another professional about their actions or decisions.

**98%** of direct and **94%** of non-direct staff strongly agreed or agreed that they were confident they would know what to do if concerned about the behaviour of a professional working with or having access to children and young people.

**90%** of direct and **94%** of non-direct staff strongly agreed or agreed that they had a clear understanding of what anti-racism means and what it is to be anti-racist in practice.

**73%** of direct and **87%** of non-direct staff felt their workload was manageable.

**73%** of direct and **81%** of non-direct staff strongly agreed or agreed

that they could raise concerns if their workload was too high, and that action would be taken to support them.

**85%** of direct and **87%** of non-direct staff have access to good quality supervision.

**68%** of direct and **68%** of non-direct staff strongly agreed or agreed that their supervision routinely focuses on helping them to 'think family' and consider the needs of all individuals that they work with directly or with whom they have contact.

**64%** of direct and **11%** of non-direct staff strongly agreed or agreed that their supervision routinely covered whether the children they are working with have been seen and spoken to and agreed actions where this hasn't happened.

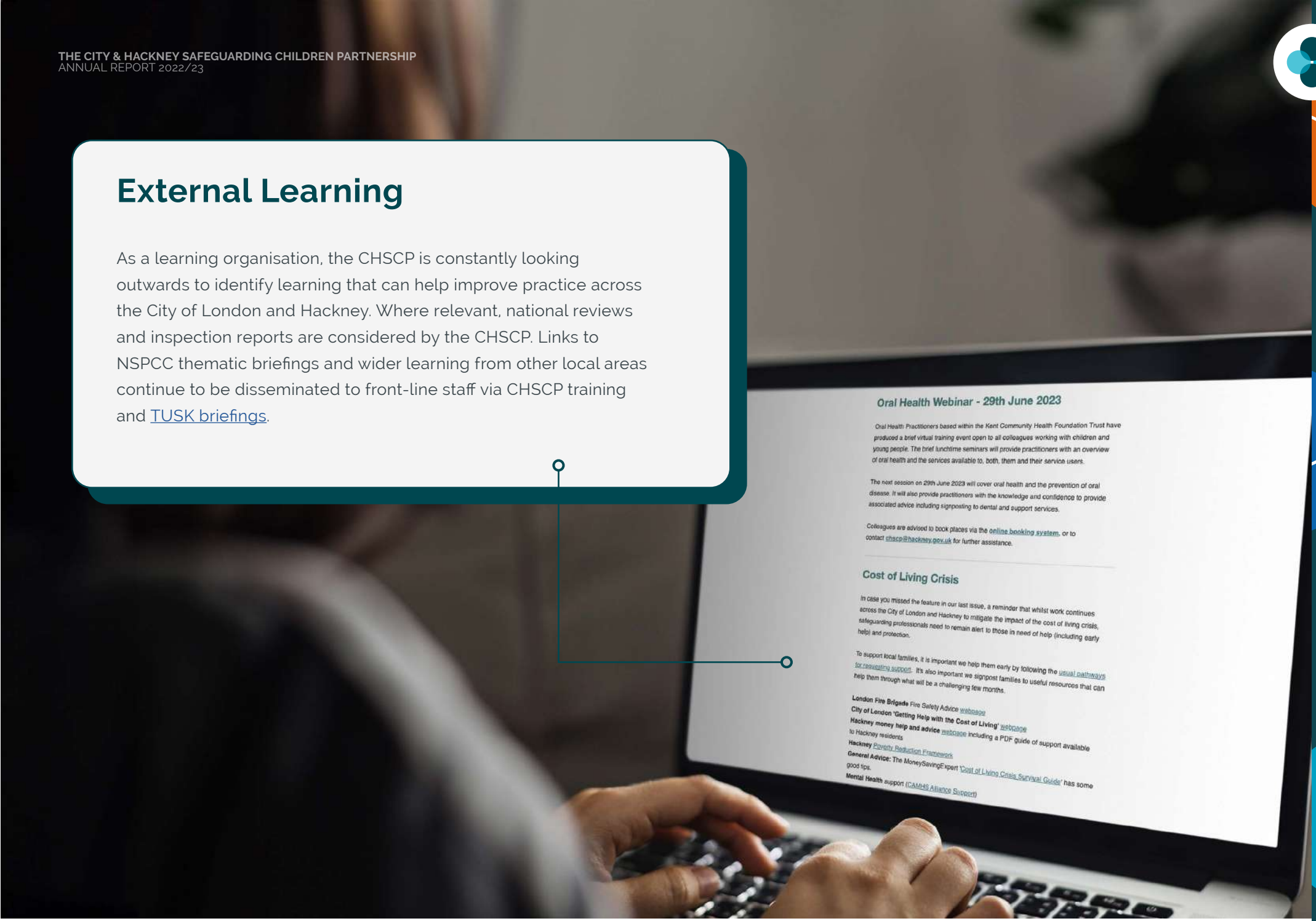
**78%** of direct and **79%** of non-direct staff indicated they were alerted to the publication of a CHSCP review by their organisation and made sure they were aware of relevant learning.

**43%** of direct and **39%** of non-direct staff strongly agreed or agreed that the cost-of-living crisis is negatively impacting upon their effectiveness at work.

**40%** of direct and **42%** of non-direct staff strongly agreed or agreed that they were thinking about changing their job due to the cost-of-living crisis.

# External Learning

As a learning organisation, the CHSCP is constantly looking outwards to identify learning that can help improve practice 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 continue to be disseminated to front-line staff via CHSCP training and TUSK briefings.



# Training & Development

# Training Summary 2021/22

The training opportunities offered by the CHSCP are designed to meet the diverse needs of staff at different levels within the wide range of organisations that work with children, young people, or adult family members. Sessions range from those that raise awareness about safeguarding and child protection to specialist topics aimed at more experienced staff. The training programme focuses on areas of practice prioritised by the CHSCP, with learning from local and national case reviews integrated into the training material. As a result of the pandemic, the CHSCP's training programme rapidly pivoted to virtual delivery and currently remains as such. The CHSCP team and trainers were swift to adapt and overall, attendance figures continue to increase from 2019/20 to present day. Feedback also remains positive with the programme continuing to improve the knowledge and skills of the safeguarding workforce.

## EVIDENCE

- **56 training sessions** were held in 2022/23 (47 in 2021/22 and 70 in 2019/20).
- **21 safeguarding topics** were covered.
- **52 of 56 courses were delivered virtually** over a 12-month period.
- **2217 available training places**, 1121 attended.
- Of the **1718 booked places**, 1121 delegates attended, 252 (14.7%) either cancelled or 345 (20.1%) did not attend the course (an increase from a combined total of 29% in 2021/22).
- **70.4%** of attended bookings are attributed to practitioners working in **Hackney**, **11.2%** in the **City of London**, and **18.4%** working across **both Boroughs**.

## EVIDENCE

The following list highlights the number of each course held with the number of delegates and the trend from 2021-22 indicated in brackets:

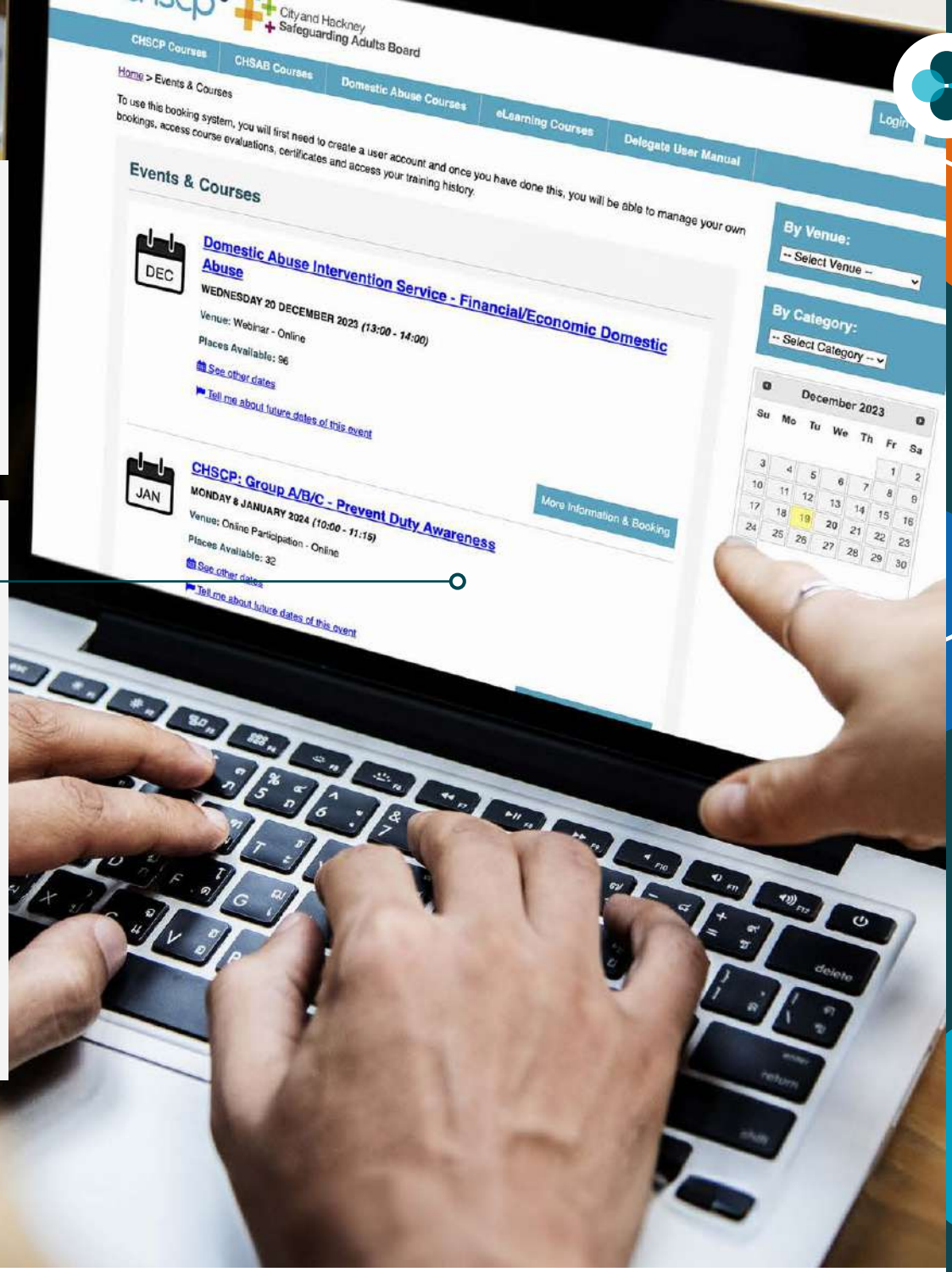
- **18*** An Introduction to Adultification courses **(363↗)**.
- **2*** Child Criminal Exploitation and County Lines **(33↗)**.
- **2*** Child Sexual Abuse Education **(26↗)**.
- **2*** Children's Wellbeing and Mental Health courses **(45↗)**.
- **3*** Designated Safeguarding Lead (Level 3) courses **(109↘)**.
- **2*** Early Help and Hackney Child Wellbeing Framework courses **(53↗)**.
- **1*** Early Help Pathway, Request for Support Form, and Assessment course **(19↗)**.
- **1*** FGM and Breast Flattening course **(31↗)**.
- **3*** Impact of Neglect and Emotional Abuse on the Development of Children and Young People courses **(56↗)**.
- **2*** Improving Professional Participation in Child Protection Conferences courses **(23↗)**.
- **1*** Incel Ideology & Extreme Misogyny Training course **(3↗)**.
- **1*** Intra-Familial Child Sexual Abuse course **(17↗)**.
- **1*** LADO: Allegations Against Staff and Volunteers course **(8↗)**.
- **1*** Non-Recent Child Sexual Abuse course **(14↗)**.
- **2*** Police Procedures courses **(18↗)**.
- **1*** Protecting Children and Vulnerable Adults from Abuse Linked to Faith or Belief course **(13↘)**.
- **4*** Safeguarding Children Basic Awareness (Level 1) courses **(158↘)**.
- **1*** Safeguarding Children with Disabilities course **(11↗)**.
- **3*** Safeguarding in a Digital World courses **(45↗)**.
- **3*** Safer Sleep courses **(60↗)**.
- **1*** Working with Cultural & Economic Diversity course **(15↘)**.

## EVIDENCE

Over the course of 2022/23, 18 Adultification sessions were delivered to the partnership (representing a 100% increase on 2021/22). A total of 268 practitioners attended, with 66 others booking, but cancelling. As of March 2023, 438 practitioners had received this training.

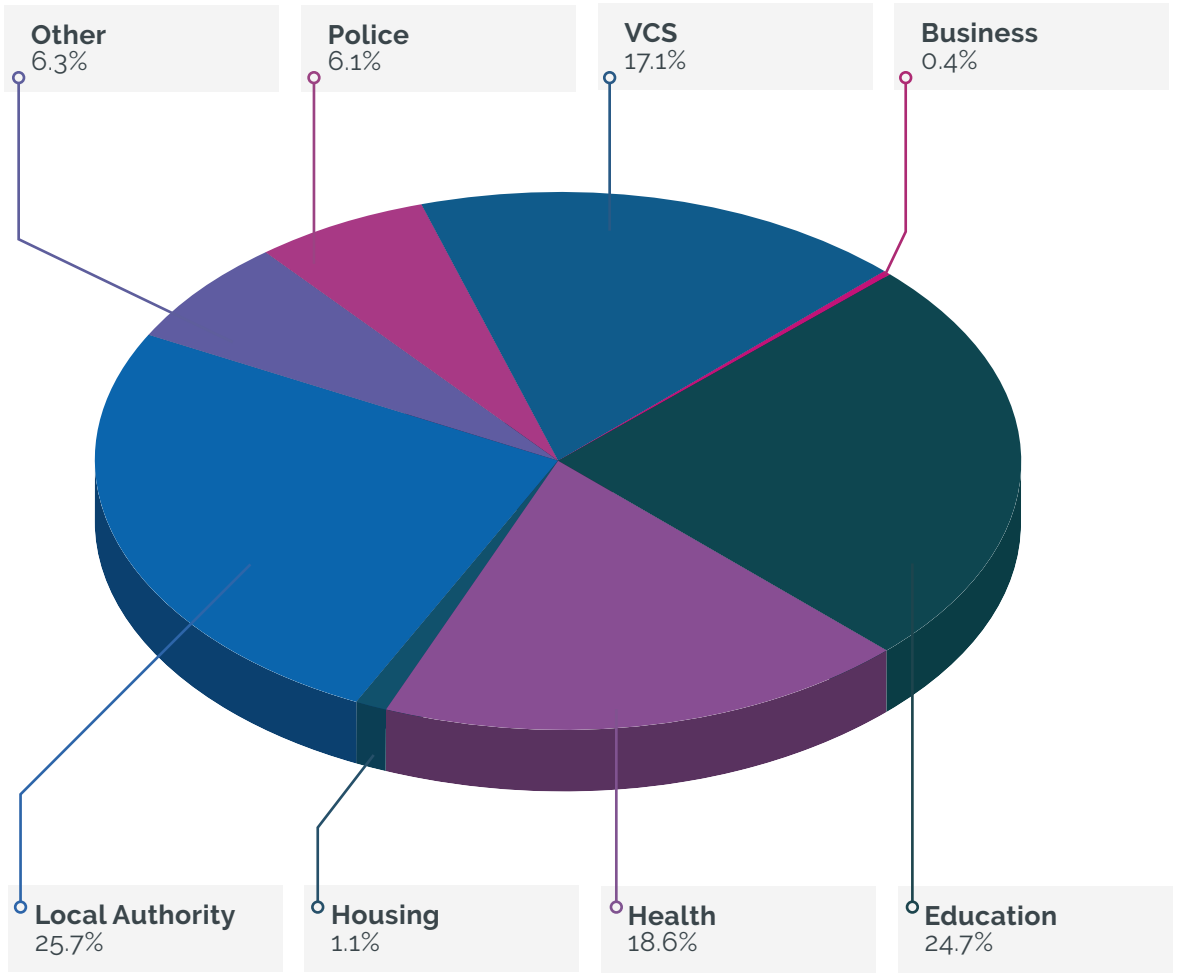
## ASSURANCE

The PHEW learning management system has been 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 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.



## DELEGATE BREAKDOWN

| Sector | Number | Percentage |
|---|---|---|
| Business | 4 | 0.4% |
| Education | 277 | 24.7% |
| Health | 209 | 18.6% |
| Housing | 12 | 1.1% |
| Local Authority | 288 | 25.7% |
| Other | 71 | 6.3% |
| Police | 68 | 6.1% |
| Voluntary and Community Services | 192 | 17.1% |
| **Grand Total** | **1121** | **100%** |



## EVALUATION

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues to monitor and evaluate the effectiveness of its core training programme. Work undertaken to review the quality of training in 2022/23 has enabled the CHSCP to gain important insight into the difference it is making towards improved outcomes for children and young people. The CHSCP is now able to provide trainers with one 'pre-level' and three 'post levels' of evaluation that include the voices of delegates and line managers.

### EVIDENCE

**98.1%** of delegates stated that the trainers' facilitation skills, teaching style and knowledge were GOOD (11.1%) VERY GOOD (33.6%) or EXCELLENT (53.4%). This is excellent feedback and a testament to the skill and expertise of our internal & commissioned trainers.

### IMPACT

**BEFORE** training 50.9% of delegates believed their knowledge was GOOD (35.4%), VERY GOOD (13%) or EXCELLENT (2.5%).

**AFTER** training 90.4% stated their knowledge was GOOD (20.4%), VERY GOOD (46.7%) or EXCELLENT (23.3%).

### IMPACT

**98.5%** stated what they had learned would help them safeguard children & young people more effectively.

**96.4%** said the course met their expectations.

## IMPACT

*"I think all aspects of the course were useful as even when I knew about some topic and issues beforehand, it is useful to mention it in case someone did not come around them yet and also for me to put everything into context and remind myself of what I know".*

**Safeguarding Children Basic Awareness, Post Evaluation.**

*"The trainer - Tony Bravo - had so much real experience of working with CYP affected by CCE and County Lines - it was helpful to get strong knowledge of what it looks like to practitioners when a YP is involved in county lines".*

**Child Criminal Exploitation and County Lines, Post Evaluation.**

*"I found the explanation on how adultification and intersectionality are linked and how they influence each other to be very insightful. Also, I was very appreciative of how the facilitator made sure to speak about how adultification works for black girls because their struggles are often overlooked".*

**An Introduction to Adultification, Post Evaluation.**

*"The team delivering the course were incredibly knowledgeable and gave lots of helpful examples to apply 'theory' to 'real life'. The case study was helpful, and it was particularly beneficial to have the process of the professionals' reports explained".*

**Improving Professionals Participation in Child Protection (CP) Conferences, Post Evaluation.**

*"I thought all aspects of the training were useful. I liked the opening activity where it helped me to reflect on my opinions".*

**Safeguarding Children Basic Awareness, Post Evaluation.**

*"[I am] more aware of ways young people can be subject to adultification by organisations and individuals, including myself."*

**An Introduction to Adultification, Level 2 Evaluation.**

*"[I have] a greater understanding of roles and responsibilities".*

**Improving Professionals Participation in Child Protection (CP) Conferences, Level 2 Evaluation.**

# Priorities & Pledge

# CHSCP Priorities 2021/22

**Priority 1: The Health & Stability of the Safeguarding Workforce**

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

**Priority 2: *Active* Anti-Racist Practice**

**Outcome:** The partnership's approach to safeguarding children and young people in a 'racialised society' is characterised by active anti-racism. This is reflected in the people employed, the policies developed, and the practice undertaken. 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 and have mechanisms in place to escalate their concerns, practitioners are confident in challenging racism and there is evidence this is being done. Children and families tell us that they can see change.

**Priority 3: The Voice of Children and Young People**

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

### Priority 4: Getting the Basics Right

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

### Priority 5: The Appetite to Learn

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

### Priority 6: Making the Invisible Visible

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

# 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 – Covid-19, organisational change, and restructure, reduced resourcing levels and increased demand. It will include evaluation of workforce stability, its capacity, and the support available to help deliver high-quality practice.

**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, children and families will see, hear and feel the difference when engaged by those responsible for their help and protection.

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

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

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

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

# What You Need to Know

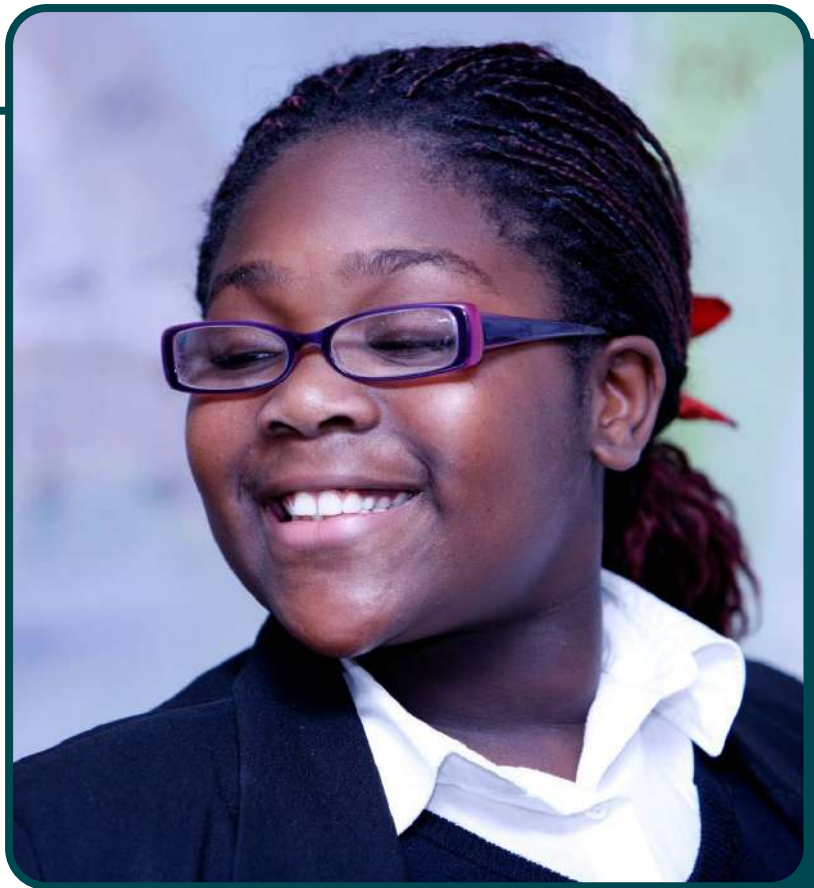
# Children and Young People

- Nothing is more important than making sure you are safe and well cared for.
- As adults, sometimes we think we always know best. We don't, and that's why your voice is so important.
- This is about you, and we want to know more about how you think children and young people can be better protected.
- We want to talk to you more often and we want 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.**

# Front-line Staff and Volunteers working with Children or Adults

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

# Local 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.


# Chief Executives and Directors

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

# The Police

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


# Head Teachers and Governors of Schools

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

# 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.**

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p. 05.02.24 v.1.0.2

An INEQE Safeguarding Group Ltd CSR Publication 2024


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