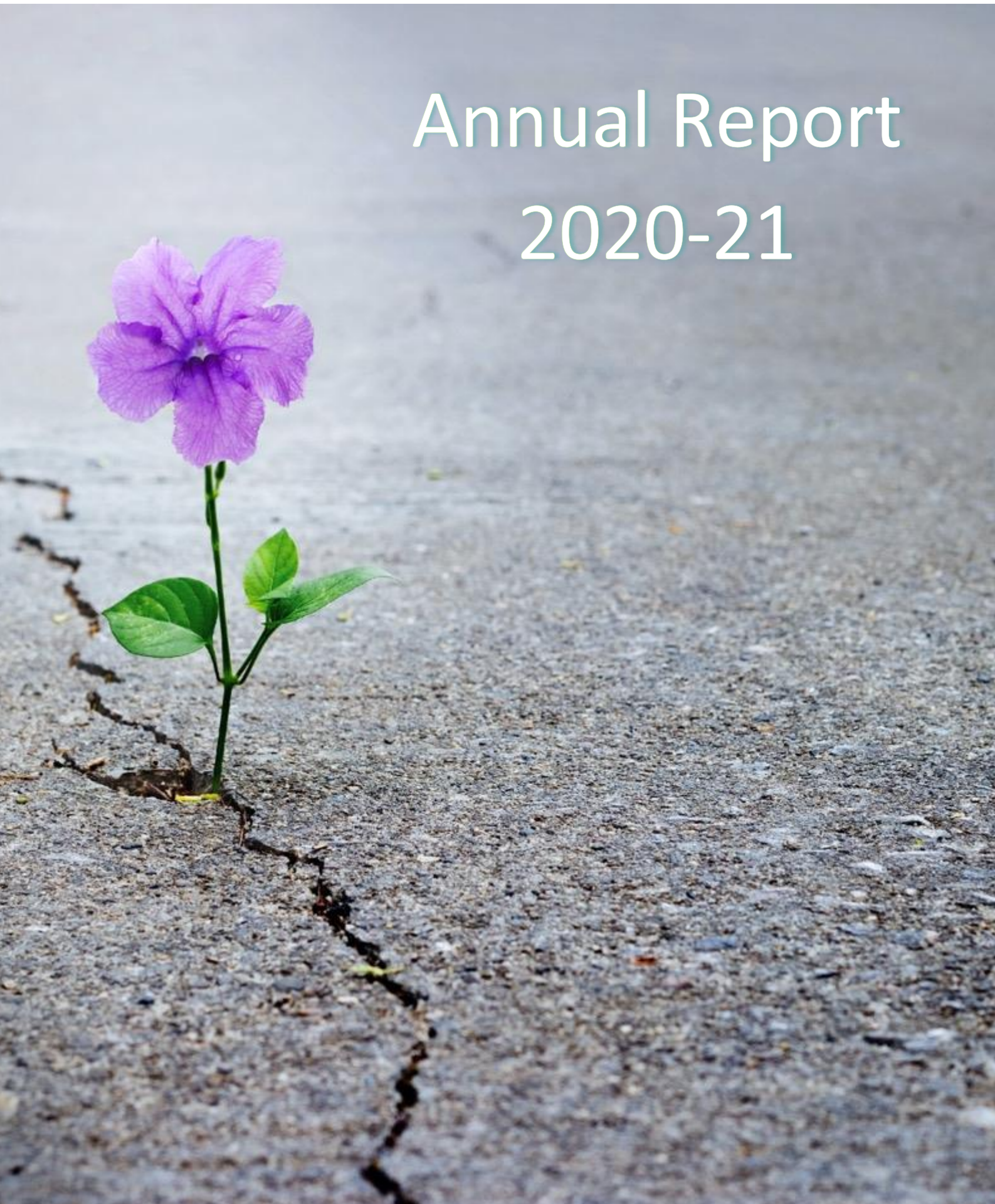
Lambeth Safeguarding Children Partnership

Annual Report 2020-21



Contents

Executive Summary

The last year has been generation-defining. The effects of the Covid-19 Pandemic, coupled with the global movements against oppression and racism, as well as our collective stand against violence against women and girls provide a powerful platform to bring us all together to facilitate a recovery that provides a new, better deal for our children and young people.

Reflections on the COVID-19 Pandemic

The response to the Covid-19 pandemic has been a truly Herculean effort across all agencies, communities and individuals in Lambeth.

Each partner agency has played its vital role in directly tackling the effects of the pandemic. Health colleagues have cared for those with Covid-19 and run a vaccination drive the scale of which has not been seen in our generation. Education colleagues innovated and adapted at pace, working in schools with children of key workers and those requiring safeguarding support while delivering a curriculum virtually. Police colleagues had the pressures of working with the community to ensure the national lockdowns were effectively enforced. Local Authority colleagues have provided food and support to those unable to leave their homes.

And, while tackling this global pandemic, all partners have kept their commitment to safeguarding children and young people in Lambeth. Colleagues in Children's Social Care, Health and Education had to quickly adapt their practice – from introducing virtual visits to continuously risk assessing children and young people to ensure those we were most worried about received the support and help they needed.

Partners worked together, meeting weekly – and often more frequently than that – to share information about staffing and safeguarding service delivery and jointly solve any issues and barriers. We have learnt much this year. We know we are able to adapt, innovate and respond to significant challenge. And while many of the specific challenges and pressures are not ones that we are keen to repeat, the learning is something that will strengthen our practice – and our partnership – going forward.

Reflections on Structural Inequality & Racism

The disproportionate impact of Covid-19 on Black, Asian and Multi-Ethnic communities, alongside the global horror caused by the murder of George Floyd and the publicisation of his final moments at the hands of one charged to protect and serve, left an indelible mark on the psyche of our children and young people, our families, our communities and our staff, many of whom reside in the borough.

This disproportionate use of force, a blunt reminder of the realities of structural and racial inequities faced by marginalised and racialised communities abroad and at home. Localised ethnic disparities remain with most of those known to our Youth Offending Service, identifying

as Black or Black British and rates of serious violence among these young people remaining high. Page 11 of this report shines a spotlight on the disproportionate representation of Black British children within statutory safeguarding services.

Our capacity to form and sustain meaningful relationships and build connections is perhaps one of our greatest resources in the fight against inequality. We recognise the value and power of understanding the impact of lived-experiences of our communities and have commissioned peer-to-peer trauma informed training for our partners, staff and key stakeholders. We are also developing our cultural competency and anti-racist approaches which, allied to our contextual safeguarding project with the Bedfordshire University and partners, will increase our capacity to support children and families with complex need and mitigate the risks posed to them with greater success.

Reflections on Gender-based Violence

The tragic murder of Sarah Everard highlighted concerns that already existed for women and girls across London's communities: that they do not feel safe when going about their daily lives. Given the location of this tragedy, the impact on local communities, partners and staff has been significant. This has reaffirmed our commitment to tackling violence against women and girls and there is no doubt we all have a key role to play in driving positive and sustainable change.

Additionally, the media attention around harmful sexual behaviour in schools connected to the 'Everyone's Invited' website has identified a lack of confidence amongst some young people in reporting sexual offences and the need to establish whether there is a cultural acceptance around sexual harassment and assault. We will conduct a multi-agency audit of our response to concerns of harmful sexual behaviour. From this, we will identify and act on ways to improve our responses to children.

We are mindful that these factors, together with the easing of lockdown restrictions, means that there will further challenges which will require a robust partnership response. In particular, we are aware of the need to urgently address Domestic Abuse and look forward to working as part of the Safer Lambeth Partnership to do so.

Training and communications form one part of our approach to improving our collective response to gender-based violence. While the Metropolitan Police is working on a new training offer, co-designed and delivered with Rape Crisis, for all frontline officers and staff to include the lived experience of victim/survivors, the Lambeth Education Designated Safeguarding Lead Forum will provide training and resources to support schools to tackle issues around harmful sexual behaviour, consent and reporting. This year we carried out a multiagency audit of our response to safeguarding children at risk of female genital mutilation (FGM). This has informed our training offer and ensuring that all professionals know that our colleagues at the Africa Advocacy Foundation are on hand for advice and can accept referrals to support children where there are concerns of FGM. In addition, we will continue to deliver monthly child exploitation workshops for practitioners and ensure all professionals have access to guidance and training through our website.

Looking ahead

As we continue to work with the restrictions and pressures of the Covid-19 pandemic, we need to address the harms that were frequently 'hidden' during the national lockdown measures and we are committed to progressing our longer-term efforts to making Lambeth a place where every child is safe and has the opportunity to develop their fullest potential. In addition, we are committed to responding to learning generated nationally, locally, and through the Independent Inquiry into Child Sexual Abuse. Looking forward to the year ahead, we are committed to delivering three overarching objectives.

Firstly, we will work together to ensure that frontline practice across the partnership demonstrates tangible improvement and learning from local and national reviews, research and innovation. ***What does this look like in practice?*** *A social worker, YOS officer, Teacher, GP, School Nurse, Safer Schools Officer and IRO discuss the learning from a recent Lambeth review and how it could help keep the young person they're working with safe.*

Secondly, we will ensure that there is an effective service to protect our young people from extra familial harm. ***What does this look like in practice?*** *A 15-year-old boy arrested in a county line hot spot later tells us that services are helping to keep him safe.*

Thirdly, we will work together to ensure practice is trauma-informed, anti-racist, and anti-oppressive. ***What does this look like in practice?*** *A family who has experienced domestic abuse is supported by their housing officer and police officer to access culturally appropriate services in order to resolve trauma.*

To ensure we are able to do this, we have changed our subgroup structures, to ensure that each of these objectives has the support and drive of leaders from across the partnership. We are committed to improving our outcomes – and our measurement of them so we are introducing a new outcomes and quality assurance framework. We are also excited about working more closely with young people to ensure their voices are at the heart of everything we do. If the year just gone has taught us anything, we know we can achieve remarkable change when we work together. We look forward to working with all of our wider partnership to do just that this year.

Andrew Eyres

Strategic Director, Integrated Health and Care

Merlin Joseph

Strategic Director, Children's Services

Clair Kelland

Detective Superintendent Public Protection, AS-CU

NHS South East London Clinical Commissioning Group

Lambeth

METROPOLITAN POLICE Working together for a safer London

Who makes up the partnership?

The Executive

Health Partners

Strategic Director, Integrated Health and Care, South East London CCG (Lambeth)

Designated Doctor, South East London CCG (Lambeth)

Designated Nurse, South East London CCG (Lambeth)

Director of Nursing, Evelina London, Guy's and St Thomas' NHS Foundation Hospital Trust

Police Partners

Detective Superintendent, Public Protection Central South Basic Command Unit

Detective Chief Inspector, Public Protection Central South Basic Command Unit

Local Authority Partners

Strategic Director, Children's Services

Director, Children's Social Care

Director, Education

Education Partners

Vice Principal, Saint Gabriel's College

Head Teacher, Herbert Morrison Primary School

Subgroups

Our subgroups are made up of representatives from:

Understanding more about children and young people in Lambeth

There are **62,085** children in Lambeth. They make up **19%** of the population.

0-4	5-10	11-17
30%	35%	35%

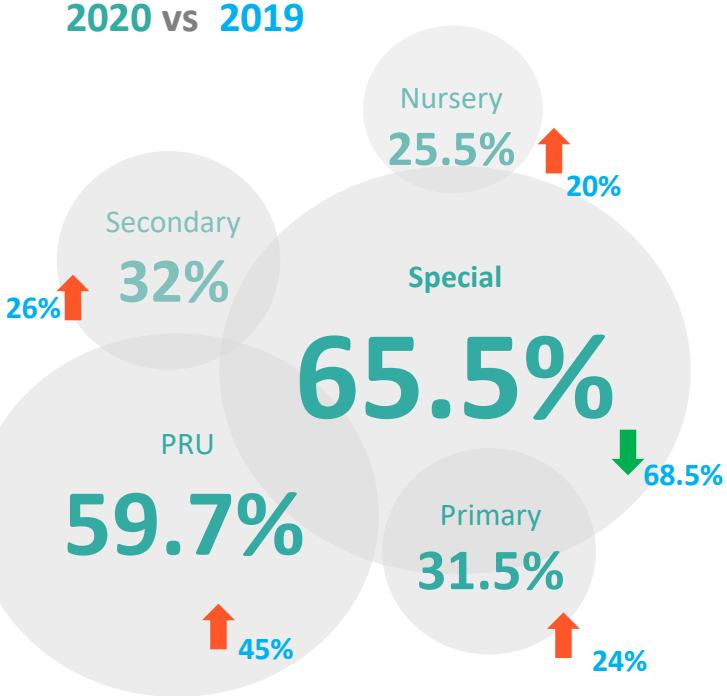
In 2019, **3,844** babies were born in Lambeth. This is **20%** lower than 9 years ago.

We have a **diversity** of children and young people

37% Black, incl. British, Caribbean, African, Other
36% White, incl. British, Irish, Other
18% Mixed heritage
5% Asian incl. Bangladeshi, Chinese, Indian, Pakistani
4% 'Other'

Children in **42.8%** of households live in **poverty**. COVID has increased the stress on families. % Free School Meals

2020 vs **2019**



Children and young people in our Pupil Referral Units are more likely to have a Special Educational Need or Disability

Primary	Secondary	PRU
15.9%	18.1%	59.7%

The average for England is 14.9%.

How many children and young people have needed extra support?

The Integrated Referral Hub received **3,274** referrals

Our Multiagency Safeguarding Hub worked together on **TBC** referrals

368 At March 2021, Children were Looked After

353 (2020)

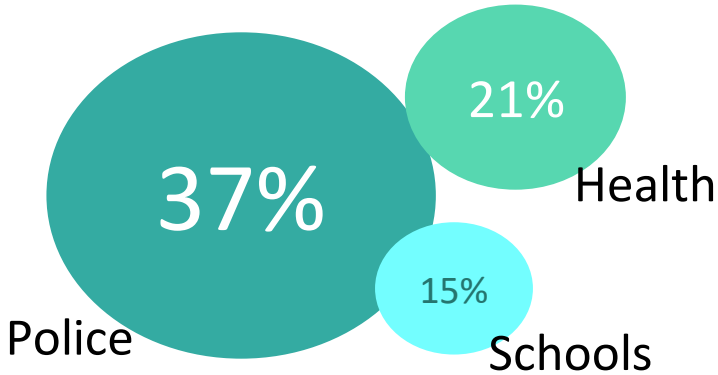
311 Children on a Child Protection Plan

230 (2020)

At March 2021, **423** Children were on a Child in Need Plan

495 (2020)

Where do referrals come from?



Main reasons for referrals

- Domestic Abuse 14%
- Physical Abuse 12%
- Sexual Abuse 7%
- Serious Violence 4%
- Parental Mental Health 4%
- Arrest of Young Person 4%

Spotlight on disproportionality

There are a disproportionate number of Children with Black British Caribbean and Black British African ethnicity who are referred for additional safeguarding support. A disproportionate

37% Black
36% White
18% Mixed heritage
5% Asian
4% 'Other'

Referrals	Child & Family Assessments	Section 47 Enquiries	Child in Need Plans	Child Protection	Children Looked After
50%	55%	57%	50%	50%	53%
17%	16% 16%	19%	21%	21%	25%
16%	6%	14%	17%	18%	16%
7%	5%	5%	5%	7%	4%
4%		3%	5%	4%	3%

Over the last year, we have completed seven Rapid Reviews. Again, the children who were the subject of these reviews were disproportionately of Black British (Caribbean and African) ethnicity.

An overview of infant death

Published in May 2021, the Southwark, Lambeth and Bromley Child Death Review Partnership reviewed Infant Deaths with Modifiable Factors in Southwark and Lambeth, 2014-2019.

Between 2014 and 2019 there was an average of 33 infant deaths per year, across both Southwark and Lambeth.

The vast majority (67%) of infant deaths occurred in the first 28 days of life. 23% of deaths occurred on the first day of life and the remaining 33% of deaths occurred within the first year of life, between 29 and 365 days of life.

The highest number of deaths occurred in term infants (born at 37+ weeks), but a second peak was also observed at 23 weeks' gestation (Figure 2).

Figure 1: Number of Infant Deaths occurring each year, by borough

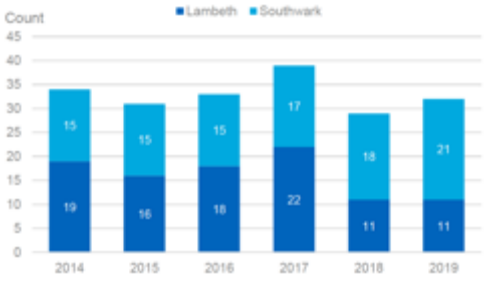
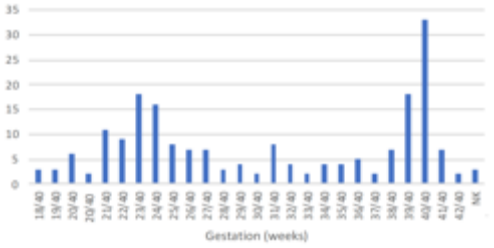


Figure 2: Deaths by Gestational Age

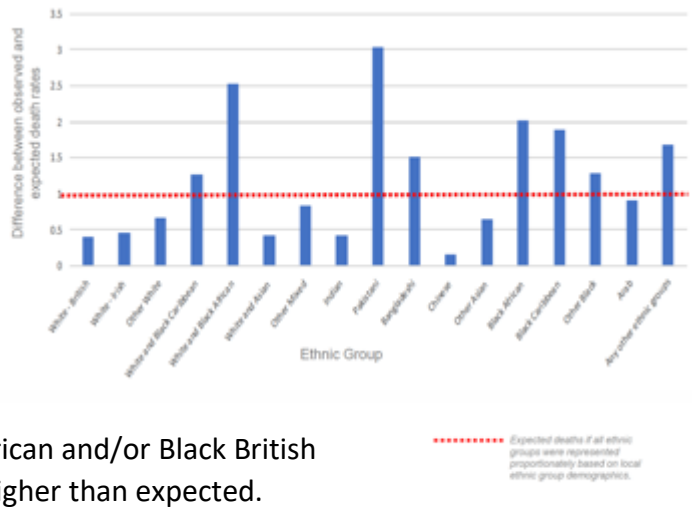


Rates of infant death are disproportionately higher among infants from ethnic minority backgrounds

Adjusting for local demographics shows that infant death disproportionately affects infants from ethnic minority backgrounds (Figure 3).

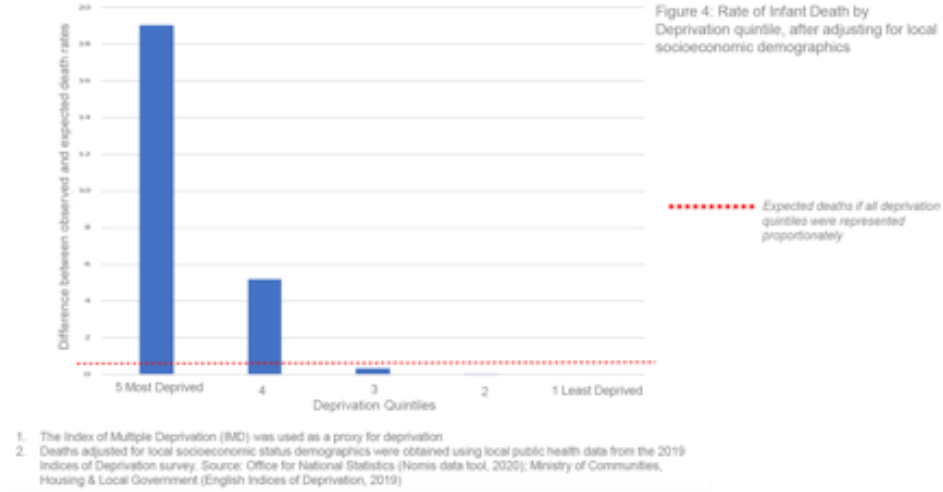
- The greatest discrepancy was observed among infants of Pakistani descent, for the infant death rate was **three times greater** than what would otherwise be expected if deaths occurred proportionately in all ethnic groups;
- The death rate was 2.5 times higher than the expected rate in infants of White and Black African mixed descent; and
- The observed death rate among infants of Black British African and/or Black British Caribbean descent was 2 times higher than expected.

Figure 3: Rate of Infant Death by Ethnic Group, after adjusting for local demographics



The majority of infant deaths occurred in the most deprived quintiles, with no deaths in the least deprived

Adjusting for local socioeconomic status demographics, the rate of death in infants who were in the most deprived quintile was **19 times higher** than would be expected if deaths were observed proportionately in all deprivation quintiles.



Modifiable factors were identified in 15% of infant deaths included in the review

Modifiable factors were identified in 15% of infant death cases included in this review (30/198 deaths), a third of which occurred in the neonatal period (1-28 days of life). 36% of modifiable deaths were attributed to Sudden Unexpected Death in Infancy (SUDI); 30% to perinatal or neonatal events; and 10% delayed recognition of severely unwell infants by parents/carers.

The presence of lifestyle and/or Public Health factors was disproportionately higher among infant deaths with modifiable factors, compared to deaths where no modifiability was identified.

Infants who died with modifiable factors present were:

- 6 times more likely to have current or historical safeguarding issues in their household;
- 5 times more likely to have a parent or carer who smoked or misused alcohol or drugs;
- 3 times more likely to: have a parent or carer with an emotional, behavioural and/or mental health condition; live in temporary/overcrowded/ asylum/insecure accommodation; or reside in a household where domestic violence was identified, respectively.

Public Health / lifestyle factors are frequently identified as contributing to cases of modifiable death

The most common cause of death where modifiable factors were present was Sudden Infant Death Syndrome (SIDS)
85% of SIDS/SUDI cases (11/13) involved at least one of the following:

- Unsafe sleeping practices;
- Alcohol/substance misuse; and
- Smoking.

It is important that repeated efforts are made by health visitors and midwives to support vulnerable families to ensure a safe sleeping environment, especially families where English is not a first language.

A significant proportion of deaths reviewed were in infants who were preterm (born at less than 34 weeks' gestation), or had intra-uterine growth restriction (IUGR). In 18% of such cases, a directly modifiable factor was identified as the primary causative agent of prematurity or IUGR. This included: maternal smoking; substance misuse; maternal BMI over 40; and domestic abuse.

The Review identified the following recommendations:

- Continue working with Health Visiting to ensure new parents are informed and encourage to adopt safe sleeping practices.
- Identify best practice and areas of improvement regarding communication and coordination of care between hospital and community teams.
- Audit of facilities for mothers in temporary housing, to ensure they are appropriate for new mothers.
- Systematic identification and provision of additional and, where necessary, culturally appropriate support for vulnerable mothers on safer sleeping practices and domestic abuse

LSCP Safer Sleep Audit

Following the sad death of Baby YM in July 2020, the LSCP surveyed Children's Social Care staff knowledge of safer sleeping advice, and we are now sharing this survey more widely in the partnership. From the 53 staff in CSC who have completed the survey:

- 38% got all questions about safer sleeping advice right
- 66% of respondents achieved 75% or more in the knowledge survey

Almost all respondents (98%) were aware that it is not safe to sleep with a baby on a sofa. This is positive as sleeping with a baby on a sofa can increase the risk of sudden infant death by up to 50 times.

Conversely, two areas were identified to address. Firstly, 32% did not judge a baby sleeping on its front as increasing risk from SIDS. However, babies placed on their front are 6 times more at risk of sudden unexpected death than a baby placed on their front. Secondly, 27% of respondents did not deem parents/carers who smoked, but not in the bedroom, to increase the risk of co-sleeping. However, the risk of SIDS is up to 10 times more if a baby shares a bed with a smoking parent. Linked to this, it has been estimated that the number of babies dying of SIDS could be halved overnight if we eliminated smoking in pregnancy.

New Safer Sleeping Advice can be found on the LSCP website at:
www.lambethsaferchildren.org.uk/safer-sleep-babies

How is our partnership scrutinised?

In November 2020, Dr Mark Peel stepped down as Independent Scrutineer. Dr Peel provided vital guidance and support to guide the transformation of the Lambeth Safeguarding Children Board into the Lambeth Safeguarding Children Partnership. Dr Peel used his significant experience to support the partnership to establish robust and transparent processes to conduct effective rapid reviews following serious safeguarding incidents. This has enabled the partnership to swiftly review practice, processes and systems to identify learning and implement improvements.

Following a competitive process, David Goosey was appointed as the partnership's new Independent Scrutineer in December 2020. David is a registered social worker with nearly 40 years' experience. In addition to his Independent Scrutineer role in Lambeth, David is the Independent Scrutineer for the Safeguarding Children Partnerships in Lewisham and Northamptonshire and chairs the Safeguarding Adult Board in Portsmouth.

The role of independent scrutiny

The Independent Scrutineer serves as a constructive critical friend, offering an independent 'high challenge, high support' perspective. As set out in *Working Together 2018*, the role of Independent Scrutineer is to provide:

Assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children and young people in Lambeth, including arrangements to identify and review serious child safeguarding cases.

Support to help the safeguarding partners consider the leadership of multi-agency safeguarding arrangements

Support for a culture and environment conducive to honest reflection, constructive challenge, and continuous improvement.

The view from the Independent Scrutineer

Safeguarding Children Partnerships across England are finding their feet following the shift from Local Safeguarding Children Boards to Partnerships. Whereas previously, the local authority was the driver of policy and practice, Partnerships require three agencies to work together closely to discharge their collective duties to safeguarding children. In Lambeth, the local authority already shared the commissioning of health-related services with the Clinical Commissioning Group for the Borough, so there is a track record of success and achievements. Working more closely with the Police Service on safeguarding children is a little more novel but just as important. From my observations, I can see a great deal of commitment from all three services to collaborate in a way that ensures the outcomes for children and young people in Lambeth are positive. The task however is huge not least because the three statutory agencies (Lambeth Council, the Clinical Commissioning Group and the Police) are not the only services that have responsibility for safeguarding children. The Partnership has to try to align all of those agencies into a coherent process. To do that on top of other things they have to do, requires constant juggling of priorities.

The top-level multi-agency safeguarding arrangements in Lambeth were amended during the later part of the year leading to this Annual Report. The new arrangements more closely support the strategic aims of the Partnership. For example, there is now a subgroup to drive the agenda to tackle racism and other forms of discrimination, and to focus practitioners to better understand the impact of trauma on the lives of children and young people. The multi-agency arrangements for frontline staff remain largely the same since these are governed by national regulations but the Partnership has a role to constantly enable those frontline practitioners to work together to safeguard children. To do this the leaders commission reviews and audits of practice and provides training. The reviews and audits provide information about how the work with children and their families is going and the training is designed to help with this vital work.

Some of the details of the reviews, audits and training is provided in this Annual Report. The formal reviews undertaken by the Partnership are governed by national regulations. The Lambeth reviews demonstrate what sometimes tragedies happen to children when their parents are unable to look after them adequately or when, as adolescents, they are subject to violence outside of the home. It is probably the case that no system of safeguarding will ever be 100% success in preventing such tragedies. The ever-present question for the Lambeth Safeguarding Children Partnership to consider is whether the system is the best it can be. The reviews and audits have provided data which shows that progress is needed in some areas. For example, more support is needed to enable front line practitioners to develop better working relationships with children and families. This is a constant challenge, but significant efforts are underway to help with this and to fill other gaps in the system.

David Goosey

LSCP Independent Scrutineer

What are our key aims?

A knowledgeable workforce: All agencies, organisations and individuals who work with children, young people and their families in Lambeth have access to the best information and processes in order to keep them safe

Quality practice: Local multiagency safeguarding practices are robust, effective, efficient and continuously improving

Collaboration on the most pressing issues facing our children and young people: Agencies working collaboratively, offering support and holding each other to account for their safeguarding practices

Snapshot: How much progress have we made on what we set out to do this year?

Ensure professionals, agencies and organisations can respond to the safeguarding challenges presented by COVID-19

Weekly Service Provision Meetings enabled joint problem solving. Guidance, resources and training provided.

Involve children and young people meaningfully in the governance of the partnership

We've been working with partners in the community & voluntary sector to make sure we get this right. We are recruiting two young people to drive this forward.

Improve the partnership's support for young people transitioning from safeguarding systems when they turn 18

We have introduced multiagency safety planning mechanisms for care leavers aged 18+. We need to introduce a transitional safeguarding framework.

Develop the partnership's ability to safeguarding young people from contextual harm

We are working with an academic team led by the University of Bedfordshire to introduce a community led response to Contextual Safeguarding. Findings will be launched September 2021.

Embed our neglect audit recommendations into practice

We have started to raise the profile of Family Group Conferences. We have provided high quality training. We need to work on developing a Neglect Strategy.

Innovate and continue to improve our communications and business processes to best support possible to our partner agencies

We continue to develop our website & newsletter as a useful hub of information & guidance. We have started developing new ways of sharing learning across the partnership.

In more detail…

A knowledgeable workforce

We trained 1,800 professionals in Lambeth

"Live" online training

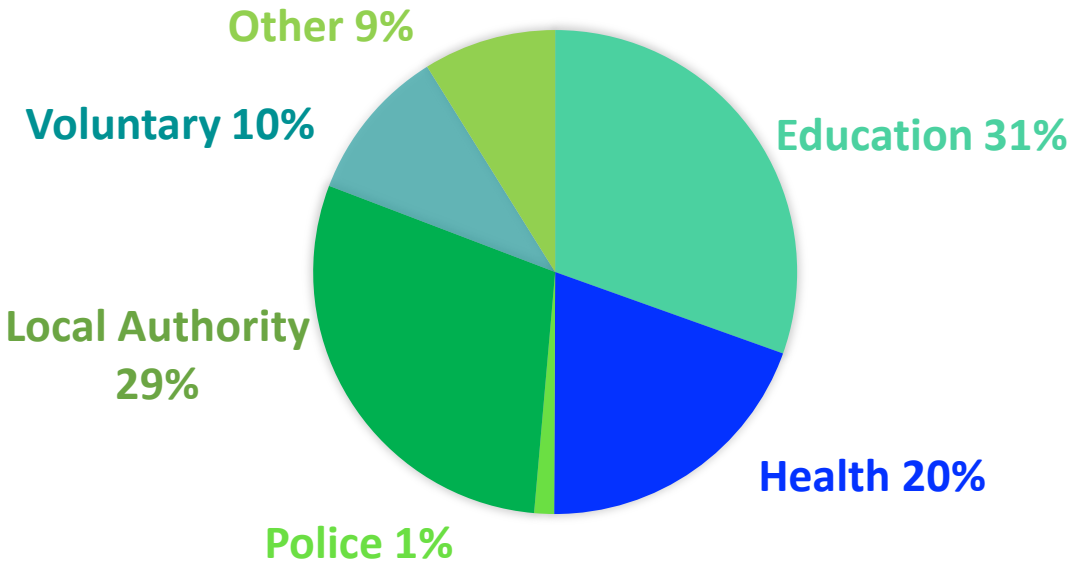
We have maintained an effective and robust multi-agency training offer throughout the COVID-19 pandemic. All the training sessions have been produced based on learnings from national and local Child Safeguarding Practice Reviews, LSCP priority areas, and findings from multi-agency audits. The Learning and Development sub-group and the Training and Development Manager have worked closely to transform courses for online delivery. The training programme remains flexible, and dates and times have changed in accordance with government guidelines and recommendations.

In 2020-21, we delivered **51** "live" online training sessions covering **17** topics for a total of **802** professionals

We ran sessions on:

- Trauma informed practice & Domestic Abuse
- Multi-agency safeguarding
- Parental learning difficulties & safeguarding children
- Supporting families with no recourse to public funds
- Safeguarding children at risk of radicalisation & extremism
- Race, Culture & Belief systems in safeguarding
- Reflective Supervision
- Safeguarding essentials for managers
- Pre-birth safeguarding
- Safer recruitment
- Safeguarding against contextual harm
- Childhood and adolescent neglect
- Disrupting Child exploitation
- Exploitation & Missing children workshop
- Unconscious Bias
- Social Media & online gaming

Training participants came from across the partnership:



Online training platform

1,031 professionals across Lambeth completed their Level 1 Safeguarding training online. This cost-effectively ensures that those who may interact with young people, even if they don't work directly with them, for example, medical receptionists, are able to spot concerns and escalate them to ensure more children and young people are protected.

Our website: a hub for Lambeth practitioners

Our website has 1,000 unique visitors a month. These visitors use the website to find out about training and access information, guidance, policy and contacts to support them as they work to keep Lambeth's children & young people safe.

We brought the wider partnership together in a forum event

In March 2021, around 90 Professionals from across the partnership came together in a Forum to launch an exciting project to develop a community-led response to contextual safeguarding.

We had the opportunity to hear from Dr Carlene Firmin who summarised the contextual safeguarding approach and introduced the project which is explored in more detail on page 21.

Carlene Firmin, 2021

Participants broke out into five discussion groups led by Professionals across the partnership. These discussion groups provided the space for professionals to reflect on some of the most pressing questions we face.

Ebinehita Iyere, Founder of Milk, Honey, Bees & Therapeutic Diversion Practitioner, DIVERTyouth, Juvenis - How can we best ensure we are working with young people to understand their lived experience and have their voice at the centre of our work?

Dan Comach, Principal Social Worker - Relationships are key – how can we embed trauma-informed responses in practice?

Patrick Ackason, Education Welfare Manager - How can we best support young people to engage or reengage in school or college?

Theresa Swann, Rescue & Response - What is a reachable moment and how can we learn from innovative approaches used in emergency situations?

Brian Kelleher, Detective Inspector: Missing Persons & Child Exploitation Teams, Met Police AS BCU - How can we understand the criminal business model of exploitation in Lambeth?

Quality practice

The Performance, Quality Assurance and Safeguarding Incidents (PQASI) Subgroup was jointly Chaired by Lambeth's Nurse Consultant, Designated Nurse, and the Assistant Director of Quality Assurance for Lambeth's Children's Social Care. They led multiagency audit activity as well as the response to notifications of serious safeguarding incidents and Child Safeguarding Practice Reviews.

Seven Rapid Reviews

During 2020-21, the LSCP completed seven Rapid Reviews following notifications of serious safeguarding incidents. Bar one, the reviews were evenly split between babies and adolescents. Three reviews related to adolescents, two who were victims of serious violence and one who was found guilty of manslaughter. Three related to babies, one who tragically died after a non-accidental injury, another who sadly died as a result of unsafe sleep practices and another, older, toddler following discovery of serious neglect.

While rapid, these reviews explored a range of safeguarding issues, including exploitation, non-accidental injury, safer sleep, child sexual abuse, neglect, school exclusion and missing education, parental mental health, and domestic abuse.

Launched three Child Safeguarding Practice Reviews

We are conducting three Child Safeguarding Practice Reviews, two of which we had completed Rapid reviews for and another we are doing in partnership with the Croydon Safeguarding Children Partnership. These reviews will be published in summer and autumn 2021 and the learning will be cascaded through training and briefing sessions.

Completed One legacy Serious Case Review

We completed a legacy Serious Case Review for Child P who was tragically murdered in the community in November 2018. The learning from this review has driven the direction and priorities of the partnership's Contextual Safeguarding Subgroup.

Completed two desktop reviews

We completed a legacy Serious Case Review for Child P who was tragically murdered in the community in November 2018. The learning from this review has driven the direction and priorities of the partnership's Contextual Safeguarding Subgroup.

Female Genital Mutilation multiagency audit

Female Genital Mutilation (FGM) is a priority in Lambeth under its Violence Against Women and Girls strategy. The Lambeth Multi Agency FGM Guidance Policy was reviewed and updated in September 2020.

Following this, we undertook a multiagency audit to quality assure the partnership's response to FGM safeguarding referrals and concerns. The audit was jointly chaired by a Service Manager from Children's Social Care and a Detective Constable from Central South BCU's Public Protection Team. The multi-agency audit employed the methodology of Joint Targeted Area Inspections (JTAIs), focusing on an 'end-to-end' review of cases. These cases were audited by a team of representatives from across the partnership. These rapid reviews

The key emerging learning themes for the partnership are to:

- Strengthen relationships between practitioners, families, and children
- Educational engagement and special educational needs
- Understand the extra familiar harm
- Improve the quality and consistency of assessments
- Understanding the live experiences of black and ethnic minority children and families

The audit highlighted several areas where multiagency practice should be strengthened, and an action plan is in place to implement improvement. Significantly, the audit found that there were limited referrals to and use of the Africa Advocacy Foundation (AAF). The AAF is Lambeth's specialist commissioned service for FGM. AAF work directly with girls, young women and their families, in a culturally informed way, to support those who have undergone FGM as well as those who are potentially at risk. AAF can also provide expert advice to professionals.

AFRICA ADVOCACY FOUNDATION

www.africadvocacy.org

Collaboration on the most pressing issues

Young people at risk

The LSCP's Contextual Safeguarding Subgroup has strategic oversight of our safeguarding responses to young people who are being, or at risk of being exploited; those who go missing from home or care; and peer-to-peer sexual harassment or abuse.

We know that our young people who are criminally exploited are at a far greater risk of serious violence. We therefore work in partnership with colleagues across the community safety partnership. In December 2020, the Lambeth Made Safer strategy was launched. This 10-year strategy takes a public health approach to reducing serious violence affecting young people. The programme's aims include:

What we have learnt from our reviews

Over the last year, we have completed a legacy Serious Case Review and three Rapid reviews all linked to criminal exploitation and serious violence. Through these reviews we have had the sombre reflection that a number of the issues and themes are mirrored and repeated in other local and national reviews.

Collaboration to develop a community-led response to contextual safeguarding

We have initiated an exciting collaboration to develop a community-led response to contextual safeguarding. The University of Bedfordshire, the University of Sheffield, the University of Huddersfield, and Royal Holloway University have formed a research team to work with the Lambeth Safeguarding Children Partnership to understand its service response to Black young men who have experienced serious harm. The team are drawing upon the 'Social Model' and 'Contextual Safeguarding' approaches to child safeguarding, to support understanding of individual, contextual, systemic, and structural harm experienced by Black young men who are, or have been, responded to by children's social care.

The research team will review anonymised case summaries provided by the partnership and will conduct a series of semi-structured interviews and focus groups with social care and multi-agency representatives in Lambeth, to explore the partnership approach in more depth. The research will help us understand how the local context impacts on Black young men's experiences of harm, and statutory responses to them. The work will also enable our understanding of the extent to which professional values, processes, practices, and partnerships are informed by and inform these contexts, and how they shape local partnership responses to young people.

The team will produce a series of recommendations for Lambeth that can be tested in consultation with young people, parents, and wider community groups in the second phase of the research. We will launch the findings in September 2021.

How is our partnership funded?

NHS SE London Clinical Commissioning Group (Lambeth)	£40,000
South London and Maudsley NHS Foundation Trust	£5,000
Metropolitan Police via Mayor's Office for Policing and Crime	£5,000
National Probation Service	£1,000
Cafcass	£550
London Fire Brigade	£500
Lambeth Council	£181,000
Total	£233,500

How have we spent our funds?

Staff Costs	£135,000
Independent oversight: Independent Scrutineer, Review Chairs, Authors, Auditors	£40,000
Training	£20,000
ICT Hardware, licences, equipment	£5,000
Total:	£200,000

What's next for 2020-2021 and beyond?

Impact frontline practice Our learning from reviews will be translated into tangible actions and will inform an effective programme of training and change. 	**Trauma-informed & anti-racist practice** We will train champions and senior leaders across the partnership to build capacity to embed trauma-informed practice. 
Ensure that there is an effective service to protect our young people from extra familial harm Embed Contextual Safeguarding in practice & work with the University of Bedfordshire to pilot a community-led response to contextual harm 	**Involve children and young people meaningfully in the governance of the partnership** 

References for data:

Data in this report has been gathered from partner agencies.

Demographic data has been taken from The Office of National Statistics, https://www.ons.gov.uk/filters/3b907706-21bf-4afe-9cba-e8058b7818c4/dimensions