Islington Safeguarding Children Board

Annual Report 2012 - 2013

Islington Safeguarding Children Board
3 Elwood Street
London
N5 1EB

www.islingtonscb.org.uk

020 7527 4209/4234

Contents

1. Chair's Introduction 4
2. Context of the Islington Safeguarding Children Board (ISCB) 5
3. Islington Safeguarding Children Board (ISCB) statutory responsibilities 5
4. Progress on 12/13 priorities 6
5. Progress on other key work 14
6. Sub-groups' work 20
7. Child protection data (see Section 4 for analysis) 23
8. ISCB governance 27
9. 13/14 priorities and objectives 27
10. Chair's conclusion and evaluation 28

Appendix 1 – Training statistics 29
Appendix 2 – Structure chart 30
Appendix 3 – Membership 31
Appendix 4 – Attendance 33
Appendix 5 – Budget 12/13 36
Appendix 6 - Glossary of acronyms 38

1. Chair's Introduction

This has been a good year for Islington Safeguarding Children Board. Outcomes for children and young people have improved in some important ways, our partnerships have been as strong and effective as ever and the Board has done a lot of learning. We are getting better at focusing on outcomes and essentials and at evaluating what we are doing as a Board.

This year we can point to strong reductions in youth crime and teenage pregnancy, to large numbers of families with children getting early help and intervention, to fewer newly looked after children placed more than 20 miles from home and fewer young people not in education, employment or training. More teenaged parents are in education or training, Sixty three care leavers are in HE and 92% of Year 11 looked after children went on to further education or training. One hundred and two more parents are in work so their children are not growing up in workless households.

Our first annual conference focused on neglect, (which remains statistically the single most significant safeguarding issue in the borough) and was followed up by further work. Staff have said that the learning from these events will shape their practice and help them to be more effective in tackling neglect. We also devoted Board time to finding out how much we really know about each other's work, our ways of working together and the impact of these on improving the lives of children. This gave us valuable information on how to improve things and develop further.

Live input to the conference and to several Board meetings from Duncombe Primary School children gave us fresh insights into what frightens children and makes them feel unsafe. We took action on those things and reported back to the children. More work with a greater number of schools is planned for next year.

Nationally, this year has seen high levels of concern about child sexual exploitation. ISCB moved early in the year to develop a strategy and training and as a result, a significant number of children at risk have been identified and supported. We know that substance misuse, poor mental health and domestic violence are the key factors in most child protection cases. So this year we carried out an intensive investigation into domestic violence and action is now underway to try and reduce both its incidence and its impact.

After four years as Chair I am stepping down, so this is my last annual report. The Board is in good shape and well placed to undertake the enhanced role now set out by central government. Islington is forging ahead with early intervention and by next year, it should be possible to measure the impact of this work on safeguarding children. All of these positive things are entirely dependent on the hard work, expertise and dedication of the staff in all the services represented on the Board and I would like to finish by thanking them.

Janet Mokades
ISCB Independent Chair

2. Context of the Islington Safeguarding Children Board (ISCB)

In 2011 Islington was ranked as the 14th most deprived local authority area in England (out of 354) and the 5th most deprived borough in London.

Twenty nine point seven per cent of children live in lone parent households.

In 2012 a higher proportion of primary school age pupils in Islington (49%) were eligible for free school meals (FSM) compared to England (19%) as a whole. The proportion of pupils in Islington who are FSM-eligible has increased over the last 3 years, a pattern seen across the primary school sector in England as a whole.

By 2011, Islington was the most densely populated London borough with 142.6 persons per hectare. The population density of 0-18 year olds is expected to increase over the next 5 years. Many children and young people live in overcrowded households.

The total resident 0-18 year old population of Islington in 2011 was 37,569. This is around 18% of the total borough population, which is a relatively low proportion compared to other boroughs.

There are slightly more 0-18 year old males than females in 2011. Approximately a third of young people are White-British and two-thirds are Black or Minority Ethnic (BME).

2.8% of the resident 0-24 year old population is known to have a disability.

In 2012, 41% of primary school children had English as an additional language while 47% of secondary school children had English as a second language. The languages spoken by most resident pupils, aside from English, are Somali, Bengali and Turkish. Overall, there are around 120 different languages spoken in Islington schools, although this includes many that are only spoken by a handful of pupils.

3. Islington Safeguarding Children Board (ISCB) statutory responsibilities

ISCB operates within a legislative and policy framework created by the Children Act 2004 and Working Together 2013. It co-ordinates safeguarding services and evaluates the effectiveness of safeguarding within Islington.

Under an independent Chair, the ISCB works across the safeguarding continuum, although its core business is the co-ordination and scrutiny of policy, practice and services to protect children and young people within Islington.

The objectives of ISCB are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
- To ensure the effectiveness of what is done by each such person or body for that purpose

The functions of the ISCB are to:

- Develop and agree thresholds, policies and procedures
- Communicate and raise awareness
- Monitor and evaluate effectiveness
- Plan, participate and co-ordinate training
- Undertake functions related to child death
- Undertake Serious Case Reviews as necessary

The functions of the Board are discharged through the Sub-groups each of which has an annual work plan agreed by the Board (Appendix 2 – ISCB structure chart).

Members of ISCB are senior managers within their organisations who hold strategic roles in relation to safeguarding / child protection. Their role is to speak for their organisations with authority, commit their organisations on policy and practice issues, and to hold their organisations to account on their safeguarding / child protection practice.

ISCB submits its annual report to the Children & Families Partnership Board, Health and Wellbeing Board, Chief Executive of the Council, Leader of the Council, Borough Commander, CEO Whittington Health, CEO CANDI, Islington PCT/CCG and the crime commissioner. The protocol between the Children's and Families Partnership Board and ISCB clarifies their respective roles and responsibilities. The protocol recognises that the 2 Boards have complementary roles and need to work together in partnership whilst recognising their distinct functions. The ISCB is not a delivery body, but has responsibility for co-ordinating, scrutinising and evaluating practice and initiating activities which investigate and improve safeguarding.

ISCB and the Health & Wellbeing Board are in the process of finalising a protocol which will clarify their respective roles and responsibilities.

The ISCB also has dual membership with a range of other bodies responsible for delivering safeguarding services, for example, the Safer Islington Partnership.

4. Progress on 12/13 priorities

In 2012 /13, the ISCB's overarching priorities were to develop early intervention and review its effectiveness and to evaluate the effectiveness of training. Beneath these, it retained the previous year's priority focus on the core business of child protection, on teenage parents, on the transition to adulthood, domestic violence and young people at risk.

4.1 Development of early intervention

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- Families First (Early Help) Teams (achieved)
- Parental Employment Partnership (PEP) (achieved)
- Further embedding and increase in number of CAFs (achieved)
- Reduction in referrals to Children's Social Care (CSC) through improved early intervention (achieved)
- Increased number of parents in employment (achieved)

Islington has transformed early intervention services by rationalising a number of smaller projects and creating 3 Families First (FF) early intervention teams based in 3 localities across Islington. The FF teams provide a coherent offer and support up to 1,000 families per year. The teams work closely with schools in identifying families who can benefit from early help.

Evidence shows that FF is identifying families earlier when potential problems can be more easily resolved and is reaching vulnerable families.

Comparing families' baseline position with reviews conducted after intervention, improvements were demonstrated in: supporting children's learning, promoting their health, meeting their emotional needs, keeping them safe, setting boundaries, keeping routine and providing social networks. The FF teams reached over 1,000 families and completed 745 family assessments.

The Common Assessment Framework (CAF) has been further embedded and during the year agencies completed the following number of CAFs:

- Early Years - 197
- Education – Special Educational Needs (SEN) - 86
- Health - 148
- Voluntary Sector - 32
- Young People's Services - 3
- Families First - 735

There has been a 95% increase in the volume of CAFs completed since 2012:

	2010	**2011**	**2012**	**2013**
Number of new CAFs	54	338	618	1205

Families have been provided with additional support to reduce barriers to employment through Islington Working for Parents, and have had support from the Income Maximisation Team. A Resident Support Scheme has been set up so that payments can be made in exceptional circumstances to support families who are affected by the changes in welfare reform.

The Parental Employment Partnership (PEP) helps low-income or workless parents back in to employment through a personalised service to parents. Between April to December 2012, 104 parents were helped into paid employment.

Islington's 16 children's centres have seen an increase in reach to all families from 74% (April-March 2011-12) to 89% (April-March.2012-13). The reach to all target groups has increased in the last 12 months:

- Workless households - 67% to 73%
- Families in statutory overcrowding - 71% to 75%
- BME families - 73% to 81%
- Families living in social housing - 70% to 76%
- Families on low income – 67% to 72%
- Lone parents – 72% to 75%

Children's centres family support and outreach workers do outreach to families who find it difficult to engage and run targeted stay and plays at children's centres. Over 80% of families receiving family support services expressed good satisfaction with this service.

Child and adolescent mental health services (CAMHS) delivered workshops at children's centres on a range of emotional and behavioural issues affecting under 5s. Sixty-four% of parents said that they had learned something new about typical child development, and 8.6 out of 10 parents found the programmes very useful.

This early intervention work is effective in reducing some of the pressures on families and in promoting better outcomes for children. Ways of measuring the impact more specifically will need to be developed over the next year.

4.2 Overall effectiveness of safeguarding work

The Board spent time collectively looking at the overall effectiveness of the safeguarding work that it oversees.

In relation to the work of front line social workers Board members reported the following: good consultation, communication, information gathering, care plans, monitoring; effective joint working; good court applications and evidence. Areas for improvement included: length

of court proceedings; social workers to be more authoritative in court; social workers to challenge more; quality of plans; feedback following referrals; quality of some supervision. This review enabled ISCB to evaluate the effectiveness of front line social work practice and inter-agency working. The feedback was overwhelmingly positive with evidence of strong inter-agency work. Areas for development are being addressed by CSC and progress will be reviewed by ISCB.

In relation to the work of universal services with vulnerable children and families Board members reported the following:

- Schools were good at establishing the needs of children and families, making appropriate referrals, making good use of resources; the team around the school process was of good quality; recording needed to improve in some schools
- Health had increased their use of CAF, made appropriate referrals to CSC and managed disclosures well
- Across universal services there has been an increased use of CAF, good relations with the LADO into investigations, good engagement with Families First, a better understanding of shared outcomes, a good understanding of thresholds across universal and willingness to work together.

This review also enabled ISCB to evaluate the effectiveness of practice across agencies and inter-agency working. Again the feedback was overwhelmingly positive with evidence of strong inter-agency work. It provided ISCB with information for future work. Areas for development are being addressed by individual agencies and progress will be reviewed by ISCB.

4.3 Core business (child protection)

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- Reduction in re-referrals (achieved)
- Reduction in length of time with a CP plan (achieved)
- Review progress in improving engagement of fathers (partially achieved)
- Monitor the impact of the implementation of the Multi-agency Safeguarding Hub (MASH) (achieved)

The following sets out the analysis of last year's data:

- Use of CAF has increased by 95% since the previous year. This has been achieved predominantly through our Families First early intervention teams, our SEN and early years services
- Over the past 24 months 75 evidence based parenting programmes have been delivered and 750 families have benefited with completion rates of 70%. Programmes have successfully reached workless and low income households, black and minority ethnic (BME), lone parents, and those facing challenges with parenting
- Contacts by other agencies to children's social care (CSC) have decreased by 6.53%. This is likely to be due to the implementation of our new early intervention teams, Families First, who work to support families below the social care threshold
- 21.8% of contacts progressed to assessments. This is an increase of 5.25%. The increase is likely to be due to social care receiving a higher number of appropriate contacts and relates to the overall reduction in volume noted above
- The highest number of contacts with CSC comes from the police. A substantial number of these do not progress to assessments as police complete a MERLIN for every contact with a child even if this child does not require CSC input. Our new children's services contact team triages all contacts and diverts them from social care to early help where appropriate

This is evidence of effective practice in early help and at contact and referral.

- There was a 1.8% decrease in the number of re-referrals between 2010/12 and 2011/13
- An audit undertaken shows that most child in need (CiN) cases now have a child in need plan and the quality of these plans is improving. There are 900 open cases of children in need
- 36% of S47 enquiries led to an initial child protection (CP) conference in 2012-13 compared to 34% in 2011-12. This needs to be monitored during the forthcoming year as it is not helpful to draw families into child protection enquiries unnecessarily
- Low number of repeat child protection plans comparable with Statistical Neighbours (SN), 10.4% for Islington in 2012-13 and 14.9% for SN for 2011/12
- The number of children per 10,000 with child protection plans has reduced from 39 at 31 March 2012 to 34 at 31 March 2013
- The length of time with a CP plan is short. The percentage of those ceasing to be the subject of a CP Plan in 2012-13 who had been the subject of a plan for 2 years or more was 7.7% for Islington and 7.8% for SN
- There has been a significant increase in the use of care proceedings. Islington has the 3rd highest rate in London at 16.3 per 10,000, an increase of 5 per 10,000 since the previous year.

This is evidence of effective practice and shows that cases are progressed within appropriate timescales, and that either parents make the changes required of them or alternative plans are made for their children to ensure they are safe. Children are not removed from child protection plans prematurely.

- There was a reduction of 6% in children looked after (CLA) when comparing numbers from 30/03/12 (330) to 31/03/13 (310). There has been an overall decrease of 30% in CLA since 2005. Audits have concluded that the right children are looked after by the local authority

The decrease in the numbers of CLA demonstrates the effectiveness of early intervention, alternative solutions to becoming looked after and the timeliness of permanent solutions for those who do become looked after, for example, adoption, special guardianship and rehabilitation home.

- We have reduced the number of newly looked after children who are required to be placed outside of the borough by 7%

This evidences effective placement commissioning which supports the protection of children by ensuring they remain close to their home address.

- Mothers attended 82% (same as previous year) and fathers 54% (increase of 9% on previous year) of C P conferences they were invited to

This evidences that our work to engage fathers has been successful and that we do well to engage our parents in general.

- Fifty-six per cent of families with CP plans had domestic violence (DV) as a contributory factor, an increase of 18% on the previous year. This is followed by substance misuse, 26%, and mental health, 19%
- The predominant category of abuse is neglect, followed by emotional abuse. This concurs with the national picture. Children suffer neglect and emotional abuse due to witnessing domestic violence, or having their development impaired due to their parent's mental health and/or substance misuse
- There has been a further reduction of the number of young parents who had children with child protection plans

- At 31/03/13 there were 7 children with CP plans allocated to the disabled children's team
- Since February 2013 we have identified 26 children at risk of sexual exploitation of which 17 have had a multi-agency meeting to consider and manage risk

We have increased identification of young people at risk of sexual exploitation and increased protection of those at risk. Our practice and data systems have become more developed over the last year.

- Compared to 31st March 2010 there has been no change in privately fostered children identified at 31 December 2011
- The Children's Social Care (CSC) workforce is very stable. There is no dependency on agency staffing, turnover is low and caseloads are reasonable and stable
- The Multi-agency Risk Assessment Conference (MARAC) considered 197 cases; 26 were repeats, an average monthly success rate of 14.3 cases
- Compared to 2011/12 there was a 44% decrease in serious youth violence, 36% reduction in knife crime, 46% reduction in gun crime and 3% reduction in robbery
- Over the last 24 months, 626 young people have been engaged in programmes delivered in 28 school sessions and 9 knife prevention programmes. Seventy-five per cent of this cohort did not go on to offend

This evidences effective multi-agency practice created through intelligence led and targeted partnership working, and by an appropriate balance of support and enforcement. There is a need to develop practice in working with perpetrators of domestic violence.

4.4 Teenage parents

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- Safeguarding issues are identified and resolved at an early stage (achieved)
- Reduction in teenage pregnancies (achieved)
- Increased percentage of teenage parents continuing education/access training (achieved)
- Reduction in percentage of teenage parents whose children have child protection plans (yet to be evaluated)

Conception rates have dramatically reduced. The 2011 figure represents a 41% decrease from the 1998 baseline.

Conception rates for 15-17 year olds per 1,000 of the population:

2007	2008	2009	2010	2011
50.6	55.3	48.6	44.9	34.4

There is an increase in young mothers in employment with 35.7% in February 2012 and 42.4% in February 2013

Eighty-five per cent of referred young parents accept the Family Nurse Partnership (FNP) programme. There are high levels of breast feeding amongst FNP mothers with 80% initiating and 25% at 6 months compared to a national average of 58.6% initiating and 7.8% at 6 months. One hundred per cent of FNP children are fully immunised at the end of the programme. Eighty-five per cent of FNP graduates are registered with children's centres. There are currently no FNP children subject to a CP plan.

4.5 Transition to adulthood

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- C&IFT early intervention team undertakes transitional work with CAMHS (achieved)

- Strengthened TYS-YOS operational links with Integrated Offender Management arrangements (achieved)
- Regular communication between Children and Families Board, Adult Safeguarding Board and ISCB (achieved)
- Increased number of young people with mental health problems access adult services (yet to be evaluated)
- Increased number of young people with Asperger's access adult services (yet to be evaluated)
- Fewer young people leaving prison re-offend (yet to be evaluated)
- Improved accommodation available for homeless 16 & 17 year olds (achieved)
- Young people's views are included in all decisions regarding their care plans (achieved)

C&IFT has a transition protocol with child and adolescent mental health services (CAMHS). This prevents young people slipping out of services.

Young people who have special needs and attend Moorfields are able to remain with paediatric services until they are 19. Transition is discussed and documented when the young person is almost 16. Adult services are informed about the transition. This has resulted in the smooth continuation of ophthalmic care with families confident and participating in the transition.

The learning disability transitions team has been strengthened within the adult learning disability partnership and now works with young people from 14 years. This supports the smooth transition to adult services.

CSC's 16+ team provided services to 16 and 17 year olds who faced issues related to homelessness and gaining independence. Twenty young people were assessed by this team. These young people and their families were provided with support and services to enable them to avoid homelessness, crime and gang involvement.

New hostel accommodation to provide high need support for homeless young people was opened in April and will provide emergency and medium term support to 8 young people.

4.6 Domestic violence (DV)

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- DV identified in the Common Assessment Framework (CAF) (achieved)
- Early intervention through use of CAF and LP (achieved)
- Deep dive to evaluate the effectiveness of the work to protect children from DV (achieved)
- Increased identification of women and children living with DV and action taken to protect them (achieved)
- Increased number of women engage with services to protect their children (achieved)
- Women experiencing DV are aware of what services they can access (yet to be evaluated)
- Reduction in numbers of children with CP plans exposed to DV (not achieved)

The CAF audit undertaken in January/February 2012 found that where DV was identified, the impact of DV had been discussed even when DV had not been the reason for the CAF and recommendations were appropriate.

The multi-agency deep dive into service provision for children affected by domestic abuse took place between October 2011 and May 2012. The resulting action plan included: ensuring routine questioning by health; increasing referrals to the multi-agency risk assessment conference (MARAC); training staff in the use of the appropriate risk assessment tool; further publicising DV services in all communities; Safer Islington

Partnership (SIP) and children's services to develop a co-ordinated and tiered approach to treatments/programmes for perpetrators. The action plan is being monitored by the Quality Assurance Sub-group.

The Safe Landings programme for those who have experienced DV was run in children's centres. Most parents felt that their bond with their child, ability to parent and confidence in parenting had improved as a result of attending the Safe Landings group. Children who were unable to access services before the group because of their inability to separate from their parents or their aggression towards other children, were able to participate in services after the group.

The evidence above points to significant improvements in the support offered to those subject to DV or at risk of suffering it.

4.7 Young people at risk

The aim of this priority is to reduce and manage the risk to young people caused through their own behaviour.

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- Reduction in:
  - Serious youth violence (achieved)
  - Young people involved in gangs as perpetrators or victims of violence (yet to be evaluated)
  - Knife crime (achieved)
  - Young people entering the criminal justice system (achieved)

The evidence below demonstrates how these indicators have been met.

Crime figures show that serious youth violence fell overall last year by 44 per cent. There were 102 fewer incidents of serious youth violence in 2012/13, almost 2 fewer crimes every week. Youth violence fell by 20 per cent, robbery fell by 3 per cent, gun crime by 46% and knife crime by 36%.

There has been a reduction in re-offending rates of under 18s. Young people, who were sentenced in Jan-Mar 2012, went on to commit on average 0.52 re-offences each, over a 6 month period. This is the lowest re-offending rate over 6 months since Islington started to record reoffending in 2008.

Targeted youth services (TYS) have been successful in diverting young people from the youth justice system (YJS). In 2011/12 63% of referred young people did not go on to offend. In 2012/13 the figure was 85%. There has been a 62% decrease in the number of first time entrants into the YJS since 2007/8.

The serious youth violence and gangs team has delivered school sessions and knife crime prevention programmes. Seventy-five per cent of the cohort did not go on to offend and 19% engaged in a restorative justice intervention.

Fifty-one young people who have engaged in the detached youth work team programmes over the last 2 years have achieved an accredited outcome, a recognised qualification. Over the past year, 460 young people achieved a recorded outcome, a progression in their personal development, improved behaviour and knowledge.

The Bronze multi-agency group aim to tackle serious youth crime. Bronze nominals have dropped from 51 to 39 over 24 months and their re-offending rates have dropped. Tracking of young people who were on the Bronze lists between January and June 2011 show that they went on to commit 1.35 further offences over a 12 month period compared to an average of 3.55 offences committed in the previous 12 months.

4.8 Effectiveness of training

The second overarching priority for the year was to evaluate the effectiveness of training.

The 2012/13 Action Plan identified the following actions and outcomes to meet this priority:

- The delivery and effectiveness of single and multi-agency training is audited and evaluated (partially achieved)
- Staff incorporate learning from training into their practice (partially achieved)
- Staff and managers report improvement/changes in practice following attendance at training (yet to be evaluated)

All staff delivering safeguarding training must, as a minimum, attend a train the trainer course and refresher up-dates. Both have been delivered by ISCB this year. A system of peer reviewing training was designed, and peer reviewers have received training on undertaking reviews. A sample of single and multi-agency courses will be peer reviewed in the coming year.

Member agencies completed the second ISCB audit of safeguarding training attended by their staff and volunteers covering the period from the 1st April 2011– 31st March 2012. This audit of single and multi-agency safeguarding training covered the training that is delivered, at what level, which staff are attending which training, numbers attending, staff that require training, where the gaps are and how the training gaps will be filled. It supports single agencies and the ISCB to identify training needs and levels and to plan courses accordingly. All the agencies audited reported that they had their own safeguarding training plans to ensure that their staff and volunteers have access to the appropriate training.

Two ISCB training sessions on managing allegations against staff resulted in a number of organisations changing their policies and procedures.

Joint achieving best evidence (ABE) training was undertaken between the child abuse investigation team (CAIT) and ABE trained social workers. This has increased the number of interviews held with ABE trained social workers, enhancing the effectiveness of interviews of children and young people.

Training undertaken by Families First staff has enabled their identification of children at risk.

Training attended by staff at Moorfields Eye Hospital, particularly in relation to domestic violence (DV), has resulted in referrals to Children's Social Care (CSC) in homes where there is DV.

Training delivered by Arsenal Football Club to their coaches has resulted in a decrease in poor practice cases and a higher level of best practice examples.

Comments from those attending ISCB training included the following:

'I will work more collaboratively with other professionals and phone social services for advice about families/concerns about specific children'

'I am going to address policies and practices currently in use within setting'

'I will update our policy and procedures and review our in-house CP training'

'More supervision of staff''

5. Progress on other key work

5.1 Children looked after (CLA) and care leavers

The Corporate Parenting Board is the body that agrees policy and procedures and scrutinises performance of CLA. The Board is chaired by an elected member of the Council and has multi agency representation.

The following are examples of some of the achievements for CLA which have improved their life chances and opportunities:

- More children and young people are being placed closer to their home address
- More children needing permanency are receiving it, 19 children were adopted
- Placement stability is reasonable but too many children have 3 or more placement moves
- All young people who are living in social housing tenancies have sustained that tenancy in the last year
- Sixty-three young people in Independent Futures (leaving care service) are studying at University
- Ninety-two per cent of year 11 young people in care transferred to further education or training in September 2012. Islington is one of the best nationally on this indicator
- Continuous improvements in health results; dental checks 92%, health 98% and immunisations 98%
- Eighty-two per cent of CLA Key Stage 2 young people achieved the national benchmark in English. It was 84% for all Islington schools
- There were 5.7%, 10 young people, persistently absent from school. This is Islington's lowest ever figure
- Fifty per cent increase in new adopters, 40% increase in new foster carers and 6 new supportive lodgings carers

5.2 Private fostering

An audit of the children's centres demonstrated that good strategies for identifying private fostering arrangements were in place. There are currently 10 active private fostering arrangements in place which are monitored by the private fostering panel and CiN teams.

In spite of numerous actions undertaken it has been difficult to increase notification rates. There were 7 new notifications this year. This is not different from some other London authorities. Future plans include continuing to raise awareness, target specific services and community and faith groups, provide GPs and health practices with good practice guides on registration via a newsletter and exploring joint work with Camden.

5.3 Child trafficking

Training and awareness raising on child trafficking has continued to be delivered led by the specialist social worker for trafficking, private fostering and sexual exploitation. In spite of our efforts, and in line with many other London boroughs, we are not improving our identification of trafficked children as they are kept hidden and out of sight. As a result, we held meetings with Camden to explore forming a joint child trafficking group as trafficked children are moved between boroughs. Plans with Camden are being finalised. We have also reviewed our strategy to focus on raising awareness and training key agencies that are most likely to come across trafficked children. These include, transport police, Whittington A&E department and sexual health clinics. Outcomes of the change in strategy will be reviewed at the end of the year.

5.4 Child Sexual Exploitation (CSE)

As a result of writing and disseminating our CSE strategy and a wide-spread awareness raising campaign, identification of possible CSE increased from 3 to 68 young people. Twenty-three multi-agency plan (MAP) meetings took place with support for all 23 young people. Direct work with young people was undertaken by young people's advocates. Those

who were being exploited are no longer exploited. Through diversion plans risk was reduced for those at risk, high risk was reduced to medium risk and medium risk reduced to low risk.

5.5 Harmful traditional practices (HTP)

HTP includes the following: forced marriage, 'honour' based violence, spirit possession and female genital mutilation (FGM). The joint Safer Islington Partnership (SIP) and ISCB HTP steering group have continued to raise awareness of these issues. There has been a slight improvement in reporting of possible FGM.

5.6 Prisons

Improved links have been developed with Pentonville and Holloway Prisons to safeguard children whose parents are in prison and children visiting parents in prison. Staff from CSC are supporting the prisons to improve and implement their child protection policies and procedures. PACT, the national charity that supports people affected by imprisonment, are piloting a system of referrals from custody to Families First.

5.7 ISCB annual conference

The ISCB conference was held in June 2012. The theme was neglect and a multi-agency audience of approximately 150 participants attended. Pupils from Duncombe Primary School started the day with a presentation on what makes them feel safe. They were followed by presentations from national speakers on their research findings which included approaches to working with families where there is neglect. Representatives from local agencies shared examples of good practice. Feedback from participants was overwhelmingly positive and indicated some of the learning that they wanted to incorporate into their practice. A follow-up workshop was held that covered strategies for working with families where there is neglect. As with the conference, feedback from participants was very positive with participants highlighting strategies they intended to include in their practice.

5.8 Involvement of children/young people

In November 2012 Year 6 children from Duncombe Primary School did a presentation to ISCB on the things that made them feel unsafe. The areas they highlighted were: teenagers hanging around parks and scaring younger children; safety on all estates; better lighting on quieter roads; protection from dangerous dogs. ISCB members have followed up the issues raised and changes made where possible.

ISCB consulted with the Youth Council on their views of ISCB's priorities and what priorities they would choose. They will be consulting with the young people they meet and feeding back their findings to ISCB.

5.9 Inspections

Ofsted and Care Quality Commission (CQC): Thematic inspection of joint working between children's and adult services

This inspection took place in September 2012 and focused on joint working between children's services and substance misuse services and children's services and adult mental health services. In line with the national picture, joint working between children's services and substance misuse services in Islington was more developed than between children's services and adult mental health services; there was evidence of effective and well integrated joint working when a parents' mental health deteriorated and when a parent should receive intervention around substance misuse; children's services made appropriate referrals to adult's services who responded appropriately; there was good work by local community groups to support parents with mental health problems. Areas for improvement included new guidance for adult mental health staff on recording details of children; and completing the safeguarding children's section of the assessment form; improved systems in substance misuse and mental health services for identifying young carers.

An action plan was developed to improve joint working between children's services and adult mental health services this is outlined below under point 5.10.4.

5.10 Audits

All action plans resulting from the audits listed below are monitored by the Quality Assurance Sub-group.

5.10.1 Sexual abuse

The aim of this audit was to review the quality of decision making in sexual abuse cases. It looked at 12 cases which came into CSC between 1st January and 2nd July 2012. The main findings were: all cases were reviewed by a manager within 24 hours; there were no referrals where a child was left at risk; no cases were viewed as inadequate; there were no glaring concerns regarding practice that compromised a child's safety. The main recommendations were: deputy team manager/team manager to check details of the original referral to ensure no vital information is lost; outcomes of police/crown prosecution service (CPS) decisions need to be shared with CSC; threshold guidance to be understood by deputy team managers/team managers; child protection co-ordinators to ensure that plans are SMART.

5.10.2 Child on child sexually harmful behaviours referrals to CiN service

The audit reviewed 7 referrals to the CiN service and 1 to the CLA service between 1st January and 2nd July 2012. The main findings were: in 6 cases the management of the disclosure was good / adequate; in 1 case it was inadequate and this was picked up by safeguarding and quality assurance and a strategy meeting was convened. The main recommendations were: practice guidance to be re-circulated and discussed by team managers in team meetings; where a child is exhibiting sexually harmful behaviour there needs to be a clearly identified management plan.

5.10.3 Quality of GP reports to CP conferences

This single agency audit was initiated by the sub-group in response to the Ofsted/CQC safeguarding and looked after children inspection in January/February 2012. The main findings were: there has been significant progress with the arrangements for requesting reports from GPs; the amount of detail on GP reports was variable. The main recommendations were: a revised GP report template is to be drafted and consulted upon and to include good practice guidance; agree arrangements for giving feedback to GPs on the quality of reports; improved procedure for contacting GPs about conferences.

5.10.4 Cases known to CSC and community adult mental health services

Ten case files known to CSC and adult mental health services were audited in March 2012. The key findings were: deficiencies in recording/documentation across both agencies; poor design of Rio (health data storage system) in capturing relevant information; improvement needed in joint working and information sharing. As a result of the audit the following actions have been taken: joint training has been arranged between CSC and mental health services; systems developed to improve recording; joint team manager meeting between CSC and mental health have been established; mental health workers to record care planning on child welfare; CSC purchased additional resources to aid talking with children about their parents mental health problems and helping parents talk to their children about their mental health problems. The actions taken also respond to the issues raised in the thematic Ofsted and CQC inspection of joint working between children's and adult services.

5.10.5 Referral and advice (R&A) service

Fifty cases were evaluated between January and May 2012 where R&A initially provided information and advice but subsequently decided an assessment by CiN was needed. The key findings included: good management oversight in 46 cases; historical information had been considered in 44 cases; in 46 cases the initial decision to provide information and advice was appropriate; in 4 cases there was sufficient information to suggest an

assessment was needed including 2 where there was evidence of on-going domestic violence; revision of initial decisions was done quickly; often the initial decision to provide information and advice was based on inadequate information in the referral; the subsequent decision to refer for assessment was appropriate; delays in progressing the referral occurred once it had been allocated to the CiN service; improve CiN's feedback to referrers . The following recommendations were made: review performance for CiN assessments; improve practice for giving feedback to referrers; remind CiN managers of the need to record delays in completing assessments and seeing the child.

5.10.6 Multi-agency audits

In December 2012 a multi-agency audit of 10 cases was undertaken. There were no cases where there were concerns for the safety of the children; there was prompt intervention and planning between the police and CSC and good information sharing, good evidence of working together and direct work with children and effective joint working between DV services. Areas for development included; further challenging of families not engaging in CP plans , use of pre-birth CP procedures; further development of SMART plans; identification of CiN or CLA cases in health system, improved recording of the child's voice.

5.10.7 Section 11 Audit

Member agencies and commissioned children's services groups completed the bi-annual section 11 audit. Actions that agencies need to complete to fulfil their safeguarding responsibilities are fed back to them. Their progress on completing these actions is monitored.

5.11 Islington Child death overview panel (ICDOP)

Below are the summary results for the first 5 years of ICDOP with cumulative totals in the last column:

	08-09	09-10	10-11	11-12	12-13	totals
Total deaths	19	13	17	14	**8**	**71**
Male	15	7	9	12	**4**	**47**
Female	4	6	8	2	**4**	**24**
Age bands						
0-1 month	9	8	6	2	**2**	**27**
1-12 months	5	3	2	4	**2**	**16**
1-5 years	1	0	2	1	**2**	**6**
5-10 years	3	1	4	2	**0**	**10**
10-15 years	0	0	1	4	**1**	**6**
15-18 years	1	1	2	1	**1**	**6**

Categorisation of deaths	08-09	09-10	10-11	11-12	12-13	totals
1 Deliberately inflicted injury, abuse or neglect	1	1	2	0	**0**	**4**
2 Suicide or deliberate self-inflicted harm	0	0	0	0	**0**	**0**
3 Trauma and other external factors	1	0	1	1	**1**	**4**
4 Malignancy	1	0	4	4	**1**	**10**
5 Acute medical or surgical condition	1	0	1	1	**0**	**3**
6 Chronic medical condition	3	1	2	3	**2**	**11**
7 Chromosomal, genetic and congenital anomalies	4	2	1	1	**0**	**8**
8 Perinatal / neonatal event	8	8	5	2	**2**	**25**
9 Infection	0	1	0	0	**1**	**2**
10 Sudden unexpected, unexplained death	0	0	0	1	**1**	**2**

The total numbers of deaths in 2012-13 was 8, the lowest recorded and below the average of 14 deaths per annum for this 5 year period. While there is a trend downwards, these numbers are too small to draw any statistically significant conclusions.

This year there was an equal split between male and female deaths, but overall there is a preponderance of male deaths in a ratio of 2 males to 1 female.

The age at death remains skewed towards the younger age group as would be expected. In 2012-13 there were 2 deaths in the neonatal period and a further 2 deaths between 1 month and 1 year of age. This means that half the deaths were in the first year and this is broadly consistent with the overall pattern over time with 60% of deaths occurring in the under 1 year age group.

Having not had and sudden unexpected death in infancy (cot death) for the first 3 years we have had 1 such death in the past two years.

Three of the 8 deaths were classified as ‘unexpected deaths’ as defined in Working Together, and a multi-agency rapid response was conducted in all cases.

None of the deaths in year were the subject of a serious case review.

As there is a time lag between the death and the sign off of individual cases by the panel, the deaths in year are not necessarily the same as the cases reviewed by the panel in year. Of the 13 cases whose review was completed by the panel in 2012-13, 2 were identified as being ‘potentially preventable’ and one as ‘preventable’. The modifiable factors and corresponding recommendations of the panel in these cases included:

- Reinforcement of advice on the sleeping positions of a young baby and co-sleeping
- Attention to detail and the need to follow guidelines in the recognition of the signs of deteriorating in an unwell child

5.12 Local Authority Designated Officer (LADO)

The LADO has management and oversight of individual cases where allegations are made against people who work with children.

2012/13 saw another marked increase in numbers of referrals to the LADO and an increase in range or agencies referring about different professionals. This was the dire**c**t result of the awareness raising that has taken place over the last 2 years.

Number of allegations referred to the LADO since 2006:

2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**
15	20	35	38	41	82	99

In 2012/13:

- 64 referrals were related to an allegation in the workplace
- 35 referrals were related to an issue in private life that raised concern as to an individual's future suitability to work with children

Allegations arose in the following work places:

Schools	20
Foster Carers	8
Early Years	16
Targeted and Specialist Children and Families Service	15
Health	7
Residential Care	10
Voluntary Sector (not including nurseries)	5
Police	3
Faith Sector	6
Sports	3
Housing	1
Transport	5

The referral sources were:

Schools	10
Fostering agency/ Residential Children's Homes	6
Early Years	15
Children's Social Care (including other LADOs)	37
Health	3
Police	6
OFSTED	4
Voluntary Sector	3
Adult agencies- Probation, Mental Health, Substance Misuse etc	3
Transport	2
CAFCAS	1
Independent Safeguarding Authority	1
Anonymous	1

The outcomes of these allegations were:

Unsubstantiated – *insufficient evidence to prove or disapprove the allegation.*	10
Unfounded –*the evidence suggests that the allegation is unlikely to be true.*	10 (including 2 malicious and 2 false)*
Substantiated – *proof that allegation is true.*	22
Advice Only – *Threshold not met for strategy meeting but agency needed advice about dealing with allegation.*	49
Passes to LADO in another Local Authority	8
Awaiting Outcome	1

*Additional categories were added in October 2012, false and malicious. For the purpose of this report these are included in the unfounded category and will be reported on next year.

Most allegations resulted in no further action due to allegations being unfounded or unsubstantiated. Six cases resulted in a referral being made to the Independent Safeguarding Authority (ISA) and subsequently the Disclosure and Barring Service (DBS) to request that the professional is barred from working with children.

The timescales for resolving these allegations were as follows:

Completed within 1 month	71
Completed between 1-2 months	11
Completed more than 3 months	8*
Awaiting Outcome	1
Passed to other LA	8

*The matters that took more than 3 months were mainly due to the length of time of the police investigation.

6. Sub-groups' work

6.1 Training and Professional Development

The key responsibilities of the Training and Professional Development Sub-group are to:

- Identify the inter-agency training and development needs of staff and volunteers
- Develop and plan an annual training and development plan
- Monitor and evaluate the quality of single and multi-agency training
- Ensure lessons from Serious Case Reviews (SCRs) are disseminated

As in previous years, ISCB produced the training programme in conjunction with other training providers within the borough. Anyone that works / volunteers with children / families in Islington can attend ISCB training free of charge. The courses are at Levels 1 to 6. Integral to the training is the development of better communication and understanding between different agencies to improve safeguarding. Topics covered are those identified as needed by member agencies and course participants.

Training attendance statistics are included in Appendix 1.

6.2 Quality assurance (QA)

The key responsibilities of the QA Sub-group are to:

- Develop agreed standards for inter-agency safeguarding work
- Establish and maintain appropriate mechanisms and processes for measuring the quality of inter-agency safeguarding work
- Contribute to the development of strategies to address any shortfalls in effectiveness
- Monitor and evaluate the quality of safeguarding work within individual Board partner agencies
- Contribute to the development of strategies for single agencies to address any shortfalls in effectiveness
- Audit and review the progress of the implementation of recommendations of Serious Case Reviews conducted by ISCB

In order to drive continual improvement the QA Sub-group undertook a number of single and multi-agency audits which are outlined in section 5.10. All audits resulted in action plans to further improve our safeguarding work. Compliance with these action plans is regularly monitored by the QA Sub-group.

The quality assurance frameworks of each member agencies were scrutinised by the group and suggestions made for improvement. To improve QA work in the voluntary sector the sub-group agreed that the QA framework designed by Children England should be rolled out to the voluntary sector by Children England and Voluntary Action Islington (VAI).

Child protection data has been scrutinised to identify any changes and concerns which are followed up as appropriate.

6.3 Policy & Practice

The key responsibilities of the Policy & Practice Sub-group are to:

- Continually review and monitor ISCB's policies, practices and procedures
- Plan the piloting of and / or introduce new working practices
- Maintain an up-to-date knowledge of relevant research findings
- Develop / evaluate thresholds and procedures for work with families

The sub-group has monitored member agencies' implementation of policies to identify gaps in policy implementation that need to be followed up. Monitoring of the London Safeguarding Children Board (LSCB) child sexual exploitation (CSE) guidance revealed gaps in knowledge and awareness which were passed onto and addressed by the CSE sub-group. Structures and systems were set up with the Safer Islington Partnership (SIP) to improve joint working and information sharing. This was evidenced in the joint approach to address the issues raised in the DV deep dive. A new format for CP conferences to better engage parents was developed and will commence in September 2013. A template for social workers to use with children to get their input into CP conferences was designed and disseminated. The safeguarding disabled children action plan was monitored and updated, as was the work of the trafficking and harmful traditional practices (HTP) steering groups to ensure agreed actions were implemented.

6.4 Child Sexual Exploitation (CSE)

The key responsibilities of the CSE Sub-group are to:

- Agree and monitor the implementation of a strategy and action plan to minimise harm to children and young people
- Raise awareness of sexual exploitation within agencies and communities
- Encourage the reporting of concerns about sexual exploitation
- Monitor, review and co-ordinate provision and practice

The results of the work of the sub-group have been highlighted in section 5.4.

6.5 E-safety

The key responsibilities of the E-safety Sub-group are to:

- Be a central point of contact for guidance, advice and networking
- Set out the roles and responsibilities of the E-Safety Safeguarding Lead Officers (ESLOs)
- Raise the awareness of e-safety within the borough
- Hold agencies to account, through the incorporation of the e-safety Strategy into their existing safeguarding policies
- Ensure that agencies have robust procedures in place in relation to recognition, identification, reporting and appropriate response to e-safety issues

A sample e-safety policy and procedures guidance was designed and distributed to all agencies. It includes sample templates and a flowchart to ensure that all agencies have appropriate policies and procedures and are aware of what to do when an incident arises. An e-safety page was added to the ISCB website which raises awareness of e-safety and provides updated information and guidance on all aspects of e-safety. ISCB members identified e-safety leads in their agencies whose role is to disseminate information, ensure their agencies have robust procedures in place and hold their agencies to account.

6.6 Serious case review (SCR)

The key responsibilities of the SCR Sub-group are to:

- Plan and undertake reviews of cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected
- Identify lessons from the reviews for inter-agency working and the work of individual agencies
- Produce and monitor action plans arising from SCRs and evaluate the effectiveness of their implementation

Additional recommendations and actions were added to the SCR for Child A following the completion of court proceedings. Child A, a four month baby, died in July 2009. The additional actions included awareness of Vitamin D deficiency in pregnant women and babies/children and distribution of vitamins to pregnant women. The national guidance on Vitamin D has been implemented in health provider trusts. Whittington Health has revised its policy regarding Vitamin D supplements for children. Public health received funding from Islington Clinical Commissioning Group (CCG) to provide free healthy start vitamins to all pregnant women, breastfeeding women and children under 4. All actions have been completed.

6.7 Islington Child death overview panel (ICDOP)

The key responsibilities of the ICDOP Sub-group are to:

- Collect and analyse information about each death with a view to identifying any case giving rise to the need for an SCR
- Review and respond to any matters of concern affecting the safety and welfare of children
- Review and respond to any wider public health or safety concerns arising from a particular death, or from a pattern of deaths
- Put in place procedures for ensuring that there is a co-ordinated response by the authority and its Board partners and other relevant persons to an ‘unexpected child death’

The work of ICDOP has been highlighted is section 5.11.

7. Child protection data (see Section 4 for analysis)

This section presents some of the key measures relating to our child protection and safeguarding work.

7.1 Contacts/referrals by source to Children's Social Care (CSC) 12/13 – showing main referrers

Contact Source Type	Percentages
School	9.7%
Family Member/Relative or Carer	5.2%
GP	1.3%
Health Visitor	1.2%
Hospital	6.1%
Housing Department	2.9%
Other Health Services (eg Hospice)	2.2%
Other Individual (eg MP or strangers	3.3%
Other Local Authority Services	9.3%
Other SW Staff (OT, EDT, HC Meals etc.)	2.8%
Police	39.1%

7.2 Number of children with Child Protection Plans

Month	Number with CPP	Population under 18 years	Number with CPP per 10,000 Islington under 18
Mar-09	138	33,692	49 SN* (41)
Mar-10	132	33,743	53 SN* (33)
Mar-11	112	33,743	52 SN* (33)
Mar-12	141	34,297	46 SN*(41)
Mar-13	117	34, 297	34

***** Statistical Neighbour

7.3 Category of abuse

Category	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13
Emotional	58	46	43	58	48
Neglect	75	79	61	70	60
Physical	4	7	4	6	6
Sexual	1	0	0	7	3
Multiple Categories	1	0	0	0	0
Total	138	132	112	141	117

7.4 Age range of children with Child Protection Plans

	March 2010 %			March 2011 %			March 2012 %			Mar-2013 %
Age Range	England	London	Islington	England	London	Islington	England	London	Islington	Islington
Unborn	2	NA	0	2	3	2	2	2	4	1
Under 1	12	NA	9	11	11	12	11	11	9	13
1 to 4	31	NA	33	31	30	31	31	29	30	19
5 to 9	28	NA	31	28	29	31	29	29	30	38
10 to 15	26	NA	27	25	27	24	25	26	27	28
16+	2	NA	0	2	2	0	2	2	0	1
Total %	100	NA	100	100	100	100	100	100	100	100

7.5 Ethnicity of children with Child Protection Plans

	Mar-10 %			Mar-11 %			Mar-12 %			Mar-13 %
Ethnicity	England	London	Islington	England	London	Islington	England	London	Islington	Islington
White	76.5	NA	50	76.8	43.5	54.5	75.9	45.1	43.3	52.1
Mixed	8.2		25.8	7.6	15.3	28.6	7.9	15.3	19.1	12.8
Asian or Asian British	5.4		0	5.3	13	0.9	5.4	12.2	3.5	4.3
Black or Black British	5.6		23.5	5.4	22.9	11.6	4.9	21.6	28.4	26.5
Other Ethnic Groups	1.4		0.8	1.2	2.9	2.7	1.2	2.8	2.8	1.7
Missing/Unknown	0.1		0	0	0	0	0	0	2.1	0
Refused/Not Obtained	2.8		0	3.6	2.3	1.8	4.6	3.1	0.7	2.6

7.6 Gender of children with Child Protection Plans

	March 2010 %			March 2011 %			March 2012 %			Mar-2013 %
	England	London	Islington	England	London	Islington	England	London	Islington	Islington
Female	48	NA	50	48	48	51	48	48	46	43
Male	51	NA	50	50	49	47	50	49	50	56
Unborn/Unknown	2	NA	0	2	3	2	2	3	4	1

7.7 Percentage of children with Child Protection Plans who have a disability

Children with a disability	Mar 13
Children with a disability	3%

7.8 Characteristics/contributory factors of parents who have children with Child Protection Plans*

Parental Contributory Factor	2008-09	2009-10	2010-11	2011-12	2012-13
Alcohol	67	78	59	43	67
Adult Mental Health	67	84	88	57	57
Disabled adult	2	3	5	7	4
Domestic Violence	166	151	159	124	145
Drugs	90	68	85	46	73
Learning difficulties	24	20	22	15	13
Physical chastisement		17	10	14	8
Young parent under 18	15	10	16	14	13
Total	**431**	**431**	**444**	**320**	**380**

***** A child with a child protection plan may have more than one child/parental characteristic/contributory factor

7.9 Characteristics of children with child protection plans

Children's Characteristics	2008-09	2009-10	2010-11	2011-12	2012-13
Child mental health	12	15	15	19	6
Disabled child	8	16	10	6	4
Sexual exploitation	1		3	5	4
Suspected trafficking			3	3	1
Total	**21**	**31**	**31**	**33**	**15**

***** A child with a child protection plan may have more than one child/parental characteristic/contributory factor

7.10 Attendance at Child Protection Conferences by professionals

	April 2012 - March 2013				
Agency	**Number of conferences**	**Invited**	**Attended**	**Provided reports**	**Did not attend or a provide report**
Police	282	280	183	81	16
Health Visitor	282	156	119	21	16
School Health Adviser	282	162	94	37	31
Paediatrician – hospital	282	5	3	0	2
Paediatrician – community	282	6	1	2	3
Midwife	282	29	23	3	4
Other hospital clinician	282	18	12	2	4
Education	282	141	128	7	6
GP	282	262	11	187	64
CAMHS	282	31	20	5	6
Substance Misuse	282	34	17	4	13
Voluntary	282	60	45	6	9
Total	282	1184	664	355	174

7.11 Attendance by Families at child protection conferences

Family member	**Year**	**Number of conferences**	**Invited**	**Attended**
Mothers	2010-11	320	307	227
Mothers	2011-12	240	233	192
Mothers	2012-13	282	276	224
Fathers	2010-11	320	224	122
Fathers	2011-12	240	168	76
Fathers	2012-13	282	203	110

7.12 Attendance by Families at child protection conferences

	April 2012 - March 2013			
Family member	Number of conferences	Conferences with children eligible for invitation to attend (12 or over)	Invited	Attended
Extended family members or close friends	282		Data Unavailable for full year	76
Children	282	41	30	19

7.13 Duration of Child Protection Plans

Duration	2008-09	2009-10	2010-11	2011-12	2012-13
Percentage subject to a CPP for 2+ years	2.4	2.9	3	2.5	5.7

7.14 Numbers of care proceedings issued

Date	Proceedings Issued	Number of children
April 2008-March 2009	33	45
April 2009-March 2010	56	81
April 2010 - March 2011	57	83
April 2011 - March 2012	43	64
April 2012 – March 2013	65	92

8. ISCB governance

The ISCB structure chart is included in Appendix 1, the membership list is in Appendix 3, attendance at ISCB meetings is in Appendix 4 and the budget is in Appendix 5. Attendance at Board meetings is good. The vast majority of members attend regularly. When they are unable to attend substitutes attend in their place. Some members only attend as required, for example, the UKBA representative. Where attendance is poor it is followed up resulting in improved attendance. Board members chair some sub-groups and representatives from all agencies sit on all sub-groups. Information on new services is presented at Board meetings so members are aware of them. Members are regularly sent updates on new research, legislation and guidance so they are kept aware of any changes. Most members also attended the annual conference, raising their awareness of different approaches to neglect that could be used by their organisations.

9. 13/14 priorities and objectives

- Early intervention and the impact of early help, including families that are hard to engage
- Joint work with adult services focusing on:
  - Parents with learning difficulties
  - Transition to mental health services

- Core business including:
  - Neglect
  - DV

10. Chair's conclusion and evaluation

This report is too long but there are some reasons for that. Safeguarding is complex, multi-faceted and involves many different services and organisations. The work of the ISCB covers all of these and the report reflects that. In addition, this year people have not only continued to scrutinise, evaluate, develop and improve the things they have always done. There has also been the development of a whole new approach to early intervention. This new work is for the long haul and the hope is that it will be preventative. The Board will need to develop its approach to evaluating its impact in future.

This report details some important improvements in outcomes this year. There has been a dramatic decrease in teenage pregnancies as a result of the effectiveness of multi-agency approaches, services and support that have been put in place. Work to divert young people from crime, reduce repeat offending and serious youth violence is effective as evidenced by a dramatic decrease in serious youth violence. The effectiveness of our work to improve outcomes and permanency for children looked after is shown by the educational achievements of children looked after. The work undertaken this year around sexual exploitation has resulted in 53 young people at risk being identified and supported. The investigation into domestic violence has led to planned action to better support victims and ultimately reduce their number. These improved outcomes testify to the effectiveness of multi-agency approaches, services and support that have been put in place for children.

Where the new work is concerned, there are already some promising improvements in outcomes. For example, 102 more parents are in work and school attendance by children from troubled families has improved significantly.

Audit and inspections over the year have made it clear that there is still much to be done to improve working between children's services and adult mental health and progress on this front will need to be carefully monitored. The Board has too little information about the spread and impact of its training and more will need to be done to assess this. Finally, the focus on neglect needs to be sustained.

There has been good progress in outcomes for children this year. Moreover, the Board has become stronger and more of a learning organisation. In my view it is well placed to meet the challenges of the next year and I wish my successor every success.

Appendix 1 – Training statistics

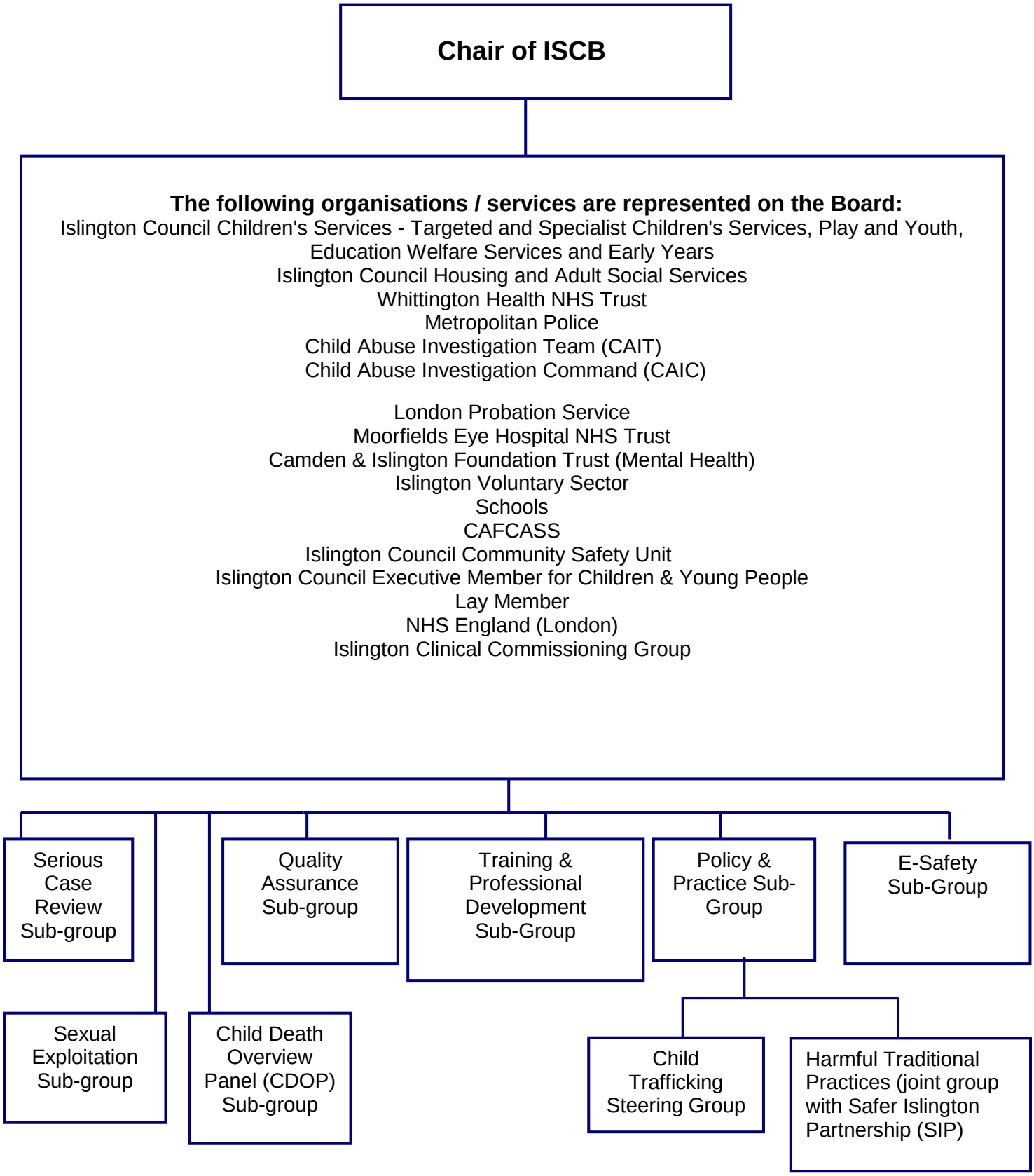
The ISCB training year runs from September to July so the statistics below cover the period from September 2012 to March 2013. Total course attendance during this period was 508.

ISCB training is delivered in addition to safeguarding training delivered by individual agencies which their staff attend. The figures below are for attendance at multi-agency safeguarding training.

The following is the ISCB course attendance breakdown by sector and service area:

SECTOR	
Statutory	270
Voluntary	166
Private	72
SERVICE AREA	
Islington Council	
Housing & Adult Services	2
CSC	44
Early years	30
Young People's Division	29
Corporate Resources	3
Education	
Non-School Based	7
School Based	14
University/College	2
Health	
Hospital	11
Community based services	90
Mental health	29
Independent Contractors	8
Non Council	
Adult Services	2
Children's Social Care	14
Early Years	55
Housing	4
Police	1
Sport and Leisure	7
Young People	62

Appendix 2 – Structure chart



Appendix 3 – Membership

NAME	TITLE	AGENCY	EMAIL
Adams, Ross	Programme Manager	Chance UK	Ross.adams@chanceuk.com
Askew, Catherine	Assistant Chief Office	London Probation Trust - Camden and Islington	Catherine.askew@london.probation.gsi.gov.uk
Bailey, Alva	Head of Community Safety	Islington Council	Alva.Bailey@islington.gov.uk
Blair, Cathy	Director, Child Protection	Islington Council	Cathy.blair@islington.gov.uk
Brooks, Patrick	Community Involvement Officer Camden & Islington	London Ambulance Service	Patrick.brooks@lond-amb.nhs.uk
Campbell, Gerry	Borough Commander	Metropolitan Police	Gerry.campbell@met.police.uk
Chapman, Jane	Designated Nurse - Child Protection	NHS North Central London (Islington)	jane.chapman@nclondon.nhs.uk
Eden, Laura	Service Manager Safeguarding and Quality Assurance	Islington Council	Laura.eden@islington.gov.uk
Fisher, Steve	North Central London LIT	UK Border Agency	Steve.fisher@homeoffice.gsi.gov.uk
Foulkes, John	DCI	CAIC	John.foulkes@met.pnn.police.uk
Friedberg, Melissa	ISCB Manager	Islington Safeguarding Children Board	Melissa.friedberg@islington.gov.uk
Gilby, Maria	ISCB Co-ordinator	Islington Safeguarding Children Board	Maria.gilby@islington.gov.uk
Hackett, Dee	Director of Operations	Whittington Health	Dee.hackett@nhs.net
Humphery, Sarah	GP	Health	sarah.humphery@nhs.net
Kenway, Penny	Head of Early Years foundation stage	Children's Services	Penny.kenway@islington.gov.uk

Luckett, Tracy	Director of Nursing	Moorfields Hospital	Tracy.luckett@moorfields.nhs.uk
Mokades, Janet	Independent Chair	Independent	Janet@janetmokades.co.uk
Norman Bruce, Ian	Head of Targeted Services	Cambridge Education @ Islington	ian.norman-bruce.camb-ed@islington.gov.uk
O'Shea, Barrie	Head teacher	Duncombe Primary School	success@duncombe.islington.sch.uk
Odling-Smee, Patrick	A D Housing and Adult Social Services	Islington Council	Patrick.odling-smee@islington.gov.uk
Oxley, Elaine	Head of Safeguarding Adults	Islington Council	Elaine.oxley@islington.gov.uk
Plant, Colin	Director Integrated Care	Camden & Islington Foundation Trust – Mental Health	Colin.Plant@candi.nhs.uk
Schooling, Eleanor	Director, Children's Services	Islington Council	Eleanor.schooling@islington.gov.uk
Watts, Richard Cllr	Lead EM	Islington Council	Richard.watts@islington.gov.uk
Wheeler, Tony Dr.	Consultant Community Paediatrician	Whittington Health	tony.wheeler@nhs.net
Yilkan, Zafer	Service Manager	CAFCASS	Zafer.yilkan@cafcass.gov.uk

Appendix 4 – Attendance

ISCB MAIN BOARD ATTENDANCE LIST

Attended	√
Did Not Attend	**x**
Apologies	**A**
Left	**L**

Name	Title	Agency		15th May 2012	17th July 2012	24th Sept 2012	20th Nov 2012	15th Jan 2013	6th March 2013
Adams, Ross	Programme Manager	Chance UK		√	√	A	√	√	√
Askew, Catherine	Acting Assistant Chief Officer	London Probation							√
Bailey, Alva	Head of Community Safety	Islington Council		√	A	√	√	√	√
Blair, Cathy	Director Targeted and Specialist Children and Families Services	Islington Council		√	√	√	√	√	A
Brooks, Patrick	London Ambulance Service	London Ambulance Service		√	√	√	A	√	A
Buckell, Maggie	Director of Operations Women Children and Families	Whittington Health		A	√	√	L	L	L
Campbell, Gerry	Borough Commander	Police				x	x	x	x
Chapman, Jane	Designated Nurse Child Protection NC London (Islington)	Whittington Health		√	A	√	√	√	√
Drury, Jackie	Director	Cam & Isl NHS Mental Health Trust & Social Care Trust		A	√	A	L	L	L
Eden, Laura	Service Manager Safeguarding Quality & Assurance	Quality and Safeguarding		√	√	√	√	√	√
Fisher, Steve	North London LIT	UK Border Agency		Attend only when necessary					
Foulkes,	DCI	CAIC							√

John									
Friedberg, Melissa	ISCB Manager	Islington Safeguarding Children Board		√	√	√	√	√	√
Gilby, Maria	ISCB Coordinator	Islington Safeguarding Children Board		√	√	√	√	√	√
Grant, Graham	Detective Chief Inspector	CAIC		A	A	L	L	L	L
Griffiths, Stephen	Voluntary Representative	CYProject		A	A	x	x	√	A
Gyford, Jane	Detective Chief Inspector	CAIC				√	√	A	L
Hackett, Dee	Director of Operations Women Children and Families	Whittington Health					√	√	A
Humphery, Sarah	GP			√	A	√	√	√	A
Kenway, Penny	Head of Early Years Service	Islington Council			√	√	√	Gwen Fitzpatrick	A
Luckett, Tracy	Director of Nursing	Moorfields Hospital		√	√	A	√	√	√
McKeown, Anthony	DI CAIT	Metropolitan Police		DCI Tim Hewitt	√	√	√	√	√
Mokades, Janet	Independent Chair	Independent		√	√	√	√	√	√
Norman-Bruce, Ian	Head of Targeted Services	Camb-ed@islington		√	√	A	A	A	√
Odling-Smee, Patrick	AD Housing and Adult Social Services	Islington Council		√	√	√	√	√	√
O'Shea, Barrie	Headteacher	Duncombe Primary School		√	√	√	√	A	√
Oxley, Elaine	Safeguarding Adults Development Manager	Islington Council		√	A	√	A	A	√
Plant, Colin	Director Integrated Care	Cam & Isl NHS Mental Health Trust & Social Care Trust					√	√	√
Ruddock,	Head of Early Years Service	Islington Council		Penny	L	L	L	L	L

Alison				Kenway					
Schooling, Eleanor	Director, Children's Services	Islington Council		√	√	A	√	√	√
Watts, Richard	Lead Member	Islington Council		√	√	√	√	A	√
Wheeler, Dr, Tony	Consultant Community Paediatrician	Whittington NHS		√	√	√	√	A	A
Wise, Mike	Borough Commander	Police		x	x	L	L	L	L
Yilkan, Zafer	Service Manager	CAFCASS		x	√	√	A	√	A

Appendix 5 – Budget 12/13

Below is the multi-agency financial contribution by partner agencies and expenditures.

INCOME 12/13	
NHS North Central London (Islington)	33,456
Metropolitan Police	5,000
Probation	2,000
Children's Services	118,754
CAFCASS (11/12 & 12/13)	1,100
Munro grant	31,882
11/12 budget carry over	5,453
TOTAL	**197,645**

EXPENDITURE 12/13

	Description	Amount
Staff	Salaries – 2.5 staff	122,148
	Staff training/conferences	575
	Travel	290
	TOTAL	**123,013**
ISCB Courses	Hire of facilities	2,187
	External trainers, E-learning package	900
	Refreshments	2,806
	Printing – information packs, leaflets, newsletter	4,012
	TOTAL	**9,905**
Board expenses	Independent chair Serious Case Review Board development Annual conference	24,599
	TOTAL	**24,599**
Office expenses	Stationery	1,758
	TOTAL	**1,758**
	TOTAL EXPENDITURE	**159,275**
Underspend	**Munro grant**	31,883
	General underspend	6,487
	TOTAL UNDERSPEND (carry over 13-14)	**38,370**

Appendix 6 - Glossary of acronyms

ABE	Achieving Best Evidence
AMASS	Adolescent Multi-Agency Specialist Service
BME	Black and Minority Ethnic
C&IFT	Camden & Islington Foundation Trust
CAF	Common Assessment Framework
CAIC	Child Abuse Investigation Command
CAIT	Child Abuse Investigation Team
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CFAB	Children and Families across Boarders
CiN	Children in Need
CLA	Children Looked After
CMHT	Community Mental Health Team
CP	Child Protection
CPP	Child Protection Plan
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CSC	Children's Social Care
CSCT	Children's Services Contact Team
CSE	Child Sexual Exploitation
CSU	Community Safety Unit
CSV	Community Service Volunteers
DBS	Disclosure and Barring Service
DV	Domestic Violence
ECPB	Executive Corporate Parenting Board
EET	Education, Employment and Training
EIP	Early Intervention and Prevention
ESLOs	E-Safety Safeguarding Lead Officers
FGM	Female Genital Mutilation
FIP	Family Intervention Project
FISS	Family Intervention Specialist Service
FNP	Family Nurse Partnership
FOSS	Family Outreach Support Service
GP	General Practitioner
HASS	Housing and Adult Social Services
ICDOP	Islington Child Death Overview Panel
ICS	Integrated Children's System
IRO	Independent Reviewing Officer
ISCB	Islington Safeguarding Children Board
IYSS	Integrated Youth Support Services
LADO	Local Authority Designated Officer
LAS	London Ambulance Service
LBI	London Borough of Islington
LGID	Local Government Improvement and Development
LP	Lead professional
LSCB	Local Safeguarding Children Board
MAP	Muti-Agency Plan
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MI	Motivational Interviewing

MPS	Metropolitan Police Service
NEET	Not in Education, Employment and Training
NFA	No Further Action
Ofsted	Office for Standards in Education, Children's Services and Skills
PCP	Person Centred Planning
PCT	Primary Care Trust
PEP	Parental Employment Partnership
PEPs	Personal Education Plans
PPD	Public Protection Desk
PRU	Pupil Referral Unit
QA	Quality Assurance
R&A	Referral and Advice
SCR	Serious Case Review
SEN	Special Educational Needs
SIP	Safer Islington Partnership
SMART	Specific, Measurable, Achievable; Realistic, Timely
SN	Statistical Neighbour
SPOC	Single Point of Contact
TAF	Team around the Family
TYS	Targeted Youth Services
UKBA	UK Border Agency
VAI	Voluntary Action Islington
YJS	Youth Justice System
YOS	Youth Offending Service
YPDAS	Young People's Drug and Alcohol Service