

Giving Children the Best Start in Life

**Islington Children and Families
Prevention and Early Intervention
Strategy
2015-2025**

Islington's Children & Families Prevention and Early Intervention Strategy 2015 – 2025

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Context

Economic recovery and its impact still seem far away. Families have less to live on and there may be more stress within them. Our children may find it harder to get work, buy their own home and face a higher cost of living than their parents. Some may need a little more support, some a lot more. This not only affects families on low incomes but people on middle incomes as well. As needs grow, there will be fewer local resources to support those needs.

Children and families need to be equipped to adapt positively to challenging life experiences at a time when there is intense pressure on public finances. Resilient children, families and communities can bounce back and thrive despite the challenges they face. Children, young people and their families can be supported in three broad ways:

- so that problems don't arise in the first place (**prevention**)
- at the first sign of a problem to prevent problems getting worse (**early intervention**)
- so that something is in place for needs or problems that are serious, will not respond to early help or will endure (**specialist intervention / treatment**).

Whilst our aim is for children, young people and parents¹ to be confident and independent through their own personal resilience and the support of social networks, this isn't always possible without the support provided by a range of services including excellent universal services delivered by a variety of partners which are available to all (early years, health services, schools, play and youth provision), and effective accessible targeted or specialist services, when needed. There is a growing body of research evidence² that suggests that intervention as early as possible pays off, early in the life of a child and early in the life of a problem. It is therefore crucial we ensure the right balance of investment across universal, targeted and specialist services and work in partnership with family members to deliver services that respond to their needs and build on their strengths, to give the best chance of making a positive difference to children's lives and to break the cycle of disadvantage. The care system, mental health in-patient services and youth offending institutions are all examples of specialist form of intervention. We know that these services cost a great deal of money. If we can prevent the need for these services we will be improving children's lives as well as making financial savings.

During good economic times, policy makers put in place the social and physical infrastructure for early intervention. As the population grows and the effects of reduced public spending begin, the risk of that infrastructure disappearing mean that problems can be stored up for the future. As a community, we risk the ability of our children, young people and families to survive and thrive.

Our challenge is how can we, across the council, health system, schools, criminal justice system, business and employment services, and the third sector invest in support that prevent problems arising in the first place or get effective help to children, young people and parents when the problems first arise?

¹ The term parent will be used throughout the strategy to include parents/carers.

² Allen (2011), 'Early Intervention, the Next Steps' and 'Early Intervention: Smart Investment, Massive Savings'; Field (2010), 'The Foundation Years: preventing poor children becoming poor adults'; Munro (2011), 'Part One: A System Analysis', 'Part Two: The Child's Journey' and Part Three: A Child Centred System'; Tickell (2010), 'The Early Years: Foundations for life, health and learning' and Marmot (2010), 'Fair Society, Healthy Lives'

The case for early intervention and prevention

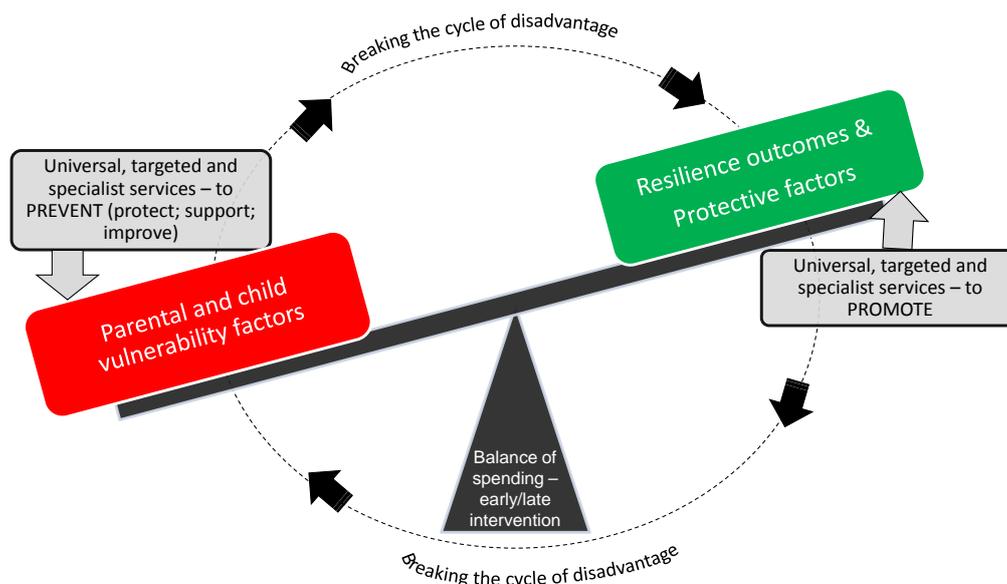
In early 2013, Islington was designated as one of 20 'Early Intervention Pioneer Places' by the [Early Intervention Foundation](#). This shows that our national profile as a leader in this area is strong. Islington will continue to make a step change so that we make early intervention a reality through all levels of local activity, from our governance structures and commissioning, development of strategies and business cases through to reviewing programmes and practice on the ground.

Our Early Intervention and Prevention Strategy is our 10-year approach to support how we work together in Islington to make early intervention and prevention our core business so that we:

- build resilience in children, young people, parents, carers and the community so that they become more self-sustaining;
- enable the impact of our investment on the lives of our children, young people and families to be seen and felt;
- continue to evaluate, develop and review how we commission for and deliver early intervention and prevention;
- make wise spending decisions and reduce duplication and costs to achieve long-term savings to society and public services

Early intervention and prevention is not a single one-off event; it is a process. It is cross-cutting and can involve multiple different factors rather than just one issue. For this reason, it requires a partnership approach. Meeting children and families' needs through early intervention will require partners to look beyond the national frameworks such as inspection and political/funding cycles. We need to embrace a local long-term strategic shift towards securing wellness and building resilience in the Islington population, hence our 10-year strategy.

What we do with children and young people will generate impact and savings for the adult population and the community. For example, social and emotional foundations in the early years, capable and confident parenting amongst vulnerable families, healthy lifestyles and good education experiences set during the primary and secondary school years can determine positive outcomes throughout the life course. It can also tackle the costly consequences of issues such as school exclusions and unemployment in later years.



We know that early intervention needs to be well-managed, particularly if families have multiple needs. This requires a partnership approach that focuses on early intervention and services working together to

secure long term well-being and resilience in the Islington population. Here, our approach to Early Help to prevent children and young people requiring expensive specialist services is important – a description of how early help services provide one element of early intervention is attached as *Appendix B*.

The challenge is to continue to support those currently in need while preventing the need for people to be supported intensively in the future. Although we are making good progress, we need to reduce the need for spend on acute and complex needs to enable better alignment of funding. Engineering a strategic shift of this kind when the pressures on public funding are intense is challenging. For the benefit of children, families and a thriving community, it is a long-term challenge we, across all areas of the children's partnership, must invest in.

The vital role of partnerships

We need to build on the work of the partnership to date to ensure we draw on the full range of resources, expertise and insight of all partners so we can better understand the needs of our children, young people and families, better identify and engage with those families who will benefit most from services, and provide co-ordinated services that effectively address needs early, to ensure the very best outcomes for our children, young people and families.

The strategy is set in the context of a very challenging economic climate which has seen unprecedented levels of central government cuts to local authority funding. During the last Children and Families Strategy 2011-15, Islington Council had to make savings of £112m. The next four year period looks as if a further £96m may have to be found which means that the council's overall budget would have been halved since 2010. Although some areas such as schools and health currently have their budgets relatively protected, there isn't a lot of money for increased investment. A collective mixture of investment from partners such as the local authority, the health service, schools, the business and third sector could help.

It is for this reason that this strategy deliberately sets out a vision for the next ten years that places early intervention and prevention at its heart. If the partnership is not able to sustain sufficient investment and with the scale of cuts envisaged this could have a major impact on our: ability to support good and outstanding universal provision; capacity to provide early intervention and preventative services; and ability to contain expenditure. The outcome could be reactive services fulfilling only narrow statutory duties for children with greatest needs at increasing cost with worsening outcomes for children and families. This 10-year strategy will therefore be the foundation for the 2015-19 Children's Services Financial Strategy.

Partnerships are the key to being able to maintain effective services and continue to improve outcomes for children. There are key partnerships between the council and health services in supporting early intervention and prevention; and also with schools (who control 71% of the overall children's services budget in the local authority). Between 2011/12 and 2014/15 the Council's overall funding has reduced by 30% with a further 30% reduction expected over the next 4 years, whilst the overall funding for the individual school budgets and the Pupil Premium has increased by 39%. The partnership between the third sector, the council and other partners is also crucial to achieving better outcomes for children and young people. Third sector partners, including community groups and volunteers, perform an important role in reaching local communities and supporting families and it is important there is further collaboration across the partnership which maximises the third sector's contribution, and its ability to lever in additional resource. Partnerships need to build on our achievements to date and encourage both the alignment of resources and more formal joint commissioning arrangements.

If we do not maintain effective early intervention and prevention services, we will be storing up problems and facing higher costs in future years.

Meeting the challenge requires a focused partnership approach. The Children and Families Board is the key strategic body for Islington in bringing key partners together.

About the Children & Families Board

The Children & Families Board brings partners across the community together in our children's partnership for the benefit of children, their families and the wider community by:

- using all of the services, workforce, finances and capital (resources) available to children, young people and parents so we can improve their lives in the best way possible
- enabling services and organisations to get support from other professionals to tackle the barriers children and families face and better meet their needs

Our role in improving children's lives is as a:

- Champion:** **for children and families**, leading the way in promoting fairness, addressing inequality, and ensuring all children and young people have the best possible life experiences and outcomes
- Catalyst:** bringing stakeholders together through shared vision and building effective partnerships to best meet need;
- Commissioner:** making best use of resources (including those specifically identified to tackle disadvantage) available through joint planning and commissioning ensuring cost effective delivery either in-house or through external providers.

The Children and Families Board develops the Children and Families Strategy in consultation with key stakeholders in the borough. The Strategy has been developed with the UN Convention of the Rights of the Child in mind. The Board has sought the views of young people and parents and the Youth Council have had an active role in shaping the strategy. In addition, the strategy has also drawn on the key messages emanating from a range of work that has been undertaken by the partnership over recent years, including the youth strategy review, the council's financial strategy, the development of the child health strategy and the priorities identified as important to Islington young people through the Youth Council elections.

The strategy is also formally agreed by the Islington Health and Wellbeing Board.

The Children and Families Strategy is closely aligned with key strategic priorities across the Council and the key partnership boards. Refer to *Appendix C*, Strategic priorities – Relevant Extracts, for details.

The Islington Children and Families Early Intervention and Prevention Strategy sets out the Vision, Principles and Priorities that will drive the work of the Partnership for 2015-2025.

Refer to Appendix E, for a diagrammatic representation of Islington Children's Partnership arrangements.

The Children and Families Board, whilst ensuring children and young people are happy, healthy, thriving and safe, will lead a collective, co-ordinated and concerted shift by all partners towards investment in early intervention and prevention. This shift will result in a more equal Islington where children, young people and their families make the very best progress, achieve excellent outcomes and accomplish their ambitions. This shift will also realise improved value for money.

Our Vision for children, young people and families in Islington

We want children and young people in Islington to have the best start in life.

By 2025 we want an Islington where they achieve the **outcomes that are important for ensuring wellbeing** at each broad developmental stage and are also able to make a successful transition to the next stage and break the intergenerational cycle of disadvantage. Whilst we acknowledge not all children start from the same point and some face a range of often complex challenges, our ambition is for all children to achieve the very best outcomes and for parents to have the knowledge, skills and confidence to provide the environment in which children can thrive. This means:

Parental outcomes

- Secure attachments and positive parenting
- Parents are managing and supporting their child's health and development
- Parents have self-belief and are capable and confident
- Positive and supportive family relationships and social networks

Child/young person outcomes Conception to 19, by developmental stage

1. Starting well:

In the early years: conception to 5 years (conception, early childhood and pre-school)

Conception to 3:

- Good physical and emotional maternal health
- Babies and young children:
 - have secure attachments and achieve optimum social and emotional development
 - have good physical health and achieve optimum physical development
 - achieve optimum communication and language development
 - are safe, are able to learn from experience and have the confidence to make positive and safe choices

3 to 5 years:

- Children have good physical and emotional health
- Children are ready for school
- Children are safe, are able to learn from experience and have the confidence to make positive and safe choices

2. Developing well:

In the primary school years: 4 to 11 years (childhood - school age)

- Children have good physical and emotional health
- Children have social and emotional capabilities including ability to problem solve, make decisions, form positive relationships and manage their feelings and behaviour
- Children are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Children achieve their full potential
- Children are ready for secondary school

In the secondary school years: 11-16 years (adolescence – school age)

- Young people have good physical and emotional health and are enabled to take more control of their health
- Young people have social and emotional capabilities, including confidence, creativity, good communication skills, resilience and determination, positive relationships and leadership skills, ability to plan and problem solve and manage feelings
- Young people are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Young people achieve their full potential
- Young people have ambitions realistic to their age and stage of development and understand the pathways that will help them achieve these

Entering young adulthood: 16 + years (young adulthood)

- Young people have social and emotional capabilities
- Young people have independent living skills
- Young people have stable, positive and respectful relationships
- Young people are and feel safe, are able to learn from experience and have the confidence to make positive and safe choices
- Young people are physically and emotionally healthy and are taking control of and managing their health well
- Young people achieve their full potential
- Young people are in appropriate education, training or employment that is line in with their abilities and aspirations

Our Guiding Principles

There are a number of important principles on which we are developing our strategy for children, young people and families. The main principle that underpins our aim and vision is:

- **Prevention and Early Intervention**

We believe that:

- investing to meet the needs of children and their families earlier is more cost-effective;
- preventing and identifying problems as early as possible should be the core business of services such as health, early years, housing and schools;
- when the need arises, targeted and specialist services should be involved to help resolve problems early, address the negative impact of disadvantage, and enable children and young people to have positive outcomes and break the cycle of disadvantage

The supporting principles to achieve our aim and vision are:

- **Good quality integrated Universal Services**

We believe that:

- a continued focus on the quality of integrated universal services, like GPs, schools, children's centres, early years, employment services, adventure play and youth services, will support children and families outcomes to be as good as, or better than, national performance.

- **Reducing Inequalities**

We believe that making Islington fairer involves:

- addressing child poverty;
- narrowing the gap in outcomes between groups in Islington and between Islington and those nationally;
- ensuring that the principles of fairness and social justice guide our priorities and actions, recognising and ensuring that characteristics that could result in inequality such as gender, race, disability, immigration status and sexual orientation do not create disadvantage

- **Think Family**

We believe that:

- children's and adult's services should *'Think Child, Think Parent, Think Family'* so that we can meet the needs of family members earlier and work co-operatively to improve outcomes and reduce unnecessary costs.

- **From Participation to Co-production**

We believe that:

- children and families co-producing or co-designing the services they use, the support they need and influencing decisions that affect them is the foundation for responsive, good quality services; building on their strengths, developing their resilience, autonomy and self-sufficiency.

- **Connecting socially for a stronger community**

We believe that:

- opportunities should be available for children, young people and families of different backgrounds to connect socially and build friendships and support networks that are essential for a stronger, more cohesive community.

- **Innovation and evidence**

We believe that:

- all providers and commissioners across statutory, commercial and third sectors should invest in services with a strong evidence base. Partners should encourage a culture of learning and innovation to drive change where there is evidence that a particular approach isn't working. We should be innovative, encourage practitioners to tell us what works and monitor outcomes and evidence of impact to develop the evidence base where gaps are identified.

Key achievements since 2011-15 Strategy

Priority 1: Improving outcomes by 19 through outstanding health services, schools and children's centres

- The gap between the Early Years Foundation Stage outcomes in Islington and those nationally narrowed from 8 in 2013 to 2 percentage points in 2014.
- Key Stage 2 results are up and above national but below London averages
- Key Stage 4 results are up and above the national and London averages
- Attainment outcomes at 19 are up but below national and London averages
- Breastfeeding and immunisation rates are up and above national averages
- Obesity rates are down but above national averages
- There has been a 38% drop in teenage pregnancy rates between 2009 and 2012.
- Over 90% of Children's Centres are good or outstanding
- 90% of schools are good or outstanding, an increase since 2011. Islington is in the top 10% of LAs in the country on this measure

Priority 2: Ensuring play, youth and leisure opportunities for children and young people

- New commissioning arrangements for 6 voluntary sector adventure playgrounds has led to increase in free open access play of 41 hours opening per week in term time and 90 hours per week in holidays with a 24% increase in participation
- Opened two major new Youth Hubs at Lift and Platform
- Outcomes-led approach to commissioning established, supported by youth outcomes framework
- Co-production of youth work services established supported through a co-produced and co-delivered quality assurance framework
- Youth Council established and involved in decision making on council investment in youth services
- Participation rates in youth services has increased and is just under 20% for 2013-14

Priority 3: Transforming early intervention and prevention support for vulnerable children and families

- CAMHS maintained in all Children's Centres and Schools despite reductions in Early Intervention and CAMHS Grants
- Selected as National Pathfinder for Community Budget for Families with Multiple Needs
- Established Families First, a new targeted family support service for 1,000 families with the first stage evaluation showing positive outcomes
- Established Specialist Multi Agency Outreach Service providing intensive support to prevent young people going into care or criminal justice system. 83% prevention rate for LAC (4 years); 'Social Return on Investment': for every £1 investment - saving of £2.57 within 1 year; £4.88 within 2 years; Saving of £970k p.a. on placement costs
- Selected as Early Intervention Pioneer Place
- CCG selected as an Integrated Care Pioneer
- Established the First 21 months programme to provide better access to services and co-ordinated support across health and early years for parents from conception to end of child's first year.

Priority 4: Ensuring children are safe at home, school and in the community

- Ofsted Safeguarding and Looked After Children Inspection: all judgements were good/outstanding
- LAC numbers down by 5% over the last 3 years
- LAC outcomes are up at KS2 and KS4 and for attendance
- LAC health assessments; immunisations; dental checks up and above national rates
- Lower rates of child protection plans than London, nationally and statistical neighbours
- Re-offending down but above national rates
- First Time Entrants down but above national rates and higher than YOT Family³
- Serious Youth Violence down by 39% and Knife Crime down by 49% between 2011/12 and 2013/14
- Reduced avoidable delay in care proceedings

³ Islington's YOT Family is made up of Lambeth, Southwark, Tower Hamlets & City of London, Camden, Hammersmith and Fulham, Hackney, Haringey, Wandsworth and Lewisham. The YOT Family average includes the Islington rate, whereas Statistical Neighbour averages exclude Islington figures.

Needs of Islington children and families

Environmental factors

There are approximately 43,500 children and young people aged 0-19 living in around 21,000 households.

Islington is a small and densely populated borough, in which there is a sharp contrast between wealth and poverty. **Poverty** is widespread, not concentrated in particular parts of the borough. 38% of children are living in income deprived households. 11% of children are living in overcrowded housing; 30% in workless households and 28% in lone parent households. Poverty is strongly linked to inequalities in health, educational achievement and long term well-being.

Approximately 44% of all school children are eligible for **free school meals** in the borough.

A significant proportion of children live in households where English is not the first language.

Parental vulnerability factors

In 2012/13, 1,600 children and young people were living in an Islington **household where offending occurred**. Children of prisoners have three times the risk of antisocial/ delinquent behaviour compared to their peers. 65% of boys with a convicted parent go on to offend compared with 22% of boys whose parents are not offenders.⁴

In 2013, 28% of assessments by Children's Social Care indicated a concern about the **mental health of a parent/carer**. Children of parents with severe and enduring mental illness can experience greater levels of emotional, psychological and behavioural problems than their peers.

484 Islington drug users in treatment in 2012/13 were recorded as adults living with children. In 2013, 4% of Children's Social Care assessments noted **parental drug misuse** and over 300 recorded **parental alcohol abuse** as a key factor. Children of **parents who misuse substances** can experience a number of negative effects. The impact can be physical, psychological and socioeconomic.

There were more than 90 children who had a social care assessment in 2013/14 who had at least one **parent with a learning difficult or disability**. Children born to parents with a learning disability are at increased risk of inherited learning disabilities and psychological and physical disorders; may suffer neglect as a result of lack of parental education and lack of support but not all parents will require the same level of support.

Given the background of some of the larger ethnic groups in Islington, there may be a significant number of girls and young women at risk of (or who have already undergone) **Female Genital Mutilation**.

Child/young person vulnerability factors

Almost one in four Islington pupils has a **special educational need or disability**, significantly higher than London and England and they face barriers that make it harder for them to learn and poorer outcomes than their peers in terms of educational achievement, physical and mental health, social opportunities and transitions to adulthood.

The proportion of young people in Islington who are **young carers** (3.1%), providing unpaid care to a family member, is higher than the London and England averages. Being a young carer can have an effect on emotional and physical health, school attendance and social networks.

⁴ NSPCC, 2011

Although the rate of **teenage pregnancy** is falling, the rate is higher than London and England.

Child Sexual Exploitation (CSE) was a concern in 78 children's social care assessments in 2013 (3%). CSE is often hidden. CSE can impact on a child's health, wellbeing and behaviour, their engagement with education, and leaves young people more vulnerable to mental health problems, teenage pregnancy and substance misuse.

Islington has a higher rate of **missing children and young people**, compared to the national average and such young people are known to be at greater risk of CSE.

Despite seeing a year on year reduction in **first time entrants** to the criminal justice system, **repeat offending** has been higher than comparators. In 2013, 113 children's social care assessments were completed in relation to 110 children and young people considered at risk of harm because of involvement in gangs.

The size of our **looked after children** population has remained stable over recent years but the needs of this group are changing, with fewer unaccompanied asylum seekers and more children with complex needs. Outcomes for looked after children are not as good as for their non-looked after peers.

Health outcomes

Areas of particular concern for child health are **oral health** (high levels of tooth decay); **obesity** and **mental health**.

Although **emergency admissions for long term health conditions** such as asthma and epilepsy are falling, the rates remain above the London rate. These children are more likely to have their education affected by health related absences and there may be negative impacts on their emotional wellbeing.

Educational attainment and employment outcomes

Although the majority of children and young people achieve a high level of **educational attainment**, a proportion of our children do not achieve their potential.

There is a strong link between **school absence** and educational attainment, so whilst our attendance rates are improving, more progress is needed.

The proportion of young people 16-18 not in education, employment and training (**NEET**) is higher than the Central London average.

Qualification levels for 19 year olds is an area requiring focus given the growing gap in employment prospects for those with no or little qualifications compared to better qualified members of the population.

A more detailed summary can be found at Appendix D and the full Joint Strategic Needs Assessment can be found <http://evidencehub.islington.gov.uk/yourarea/jsna/Pages/default.aspx>

Building on resilience factors and addressing vulnerability factors

Over the next ten years the partnership aims to focus on supporting children, young people and parents to build on resilience outcomes as well as reduce exposure to and severity and complexity of vulnerability factors, to ensure all children and young people have the best start in life. We aim to do this by focusing on 3 priorities.

Our Strategic Priorities 2015-25

In order to continue to improve outcomes for children and young people in Islington supported through an early intervention and prevention approach, we are proposing the following three priorities

Priority 1: Improving outcomes from conception to 19 through good and outstanding universal services

Early intervention and prevention is at the heart of this priority from the earliest years through to adolescence. Through places such as health settings, early years, schools, play and youth services, we will help children and young people become resilient by supporting them to develop the foundations, aspiration and social and emotional capabilities that are highly significant for good outcomes. We will continue to make safeguarding everyone's business to ensure that children are safe at home, at school and in the community. A healthy start in life and good early child development, healthy lifestyles, academic and social successes, good emotional health and skills to prepare for adult life help children overcome challenges they may face from time to time.

Priority 2: Strengthening our early help support for children and families who have additional needs

Stable families where parents are able to meet their children's needs and provide good care for them are good for children, families and the wider community. Families facing many disadvantages (such as low income, poor health and housing, domestic violence, parental mental and physical ill-health, parental substance misuse) are at greater risk of outcomes such as unemployment, school exclusion, anti-social behaviour and offending, with a large cost to society and a continuing cycle of disadvantage. With high local rates of child poverty; supporting parents and carers into work that means they are better off (both financially and in terms of their broader well-being) is the best route out of poverty. Duplication and lack of co-ordination are a poor use of resources.

We need to further develop our system of early help for families with multiple needs, ensuring access to the right services and support, delivered at the right time, in places where people can use them. Interventions need to be co-ordinated and targeted to ensure they bring about sustainable change, are proportionate to risk and reduce the need for treatment or statutory services. This will help to reduce what we currently spend on specialist services and enable reinvestment into services that prevent problems arising in the first place and get effective help to children, young people and families when problems first arise.

Priority 3: Supporting our most vulnerable children to be safe and thrive and to be able to overcome the challenges they face as they grow up

Where children and young people experience trauma (including abuse and neglect), difficulties or stresses in their lives, we need to ensure that they have the effective support to overcome the odds and go on to achieve successful lives. For some children, particularly disabled children, children with special educational needs, looked after children and children with long-term conditions, we will work in ways that builds their social and emotional skills, enabling them to better recognise their strengths, build resilience, respond to risks and challenges and take up opportunities that they recognise as important for their long term wellbeing

In our last strategy, we included a priority to ensure play, youth and leisure opportunities for children and young people. This work has been progressed significantly since the last strategy with the completion of major reviews of adventure play and universal youth provision. The important continued contribution of play and youth services is built into our three strategic priorities.

Related appendices

Appendix A provides a more detailed breakdown of the priorities and actions proposed over the next five years to support the strategy

How we will review our strategic approach

The Children and Families Board will monitor and review the effectiveness of the partnership in engaging with children, young people and families that builds resilience and addresses needs early.

The Board will monitor how well young people's outcomes compare with London averages to ensure our children and young people are doing as well as or better than their peers. The Board will make a concerted effort to drive better outcomes for children and young people who are more vulnerable and will monitor the extent to which we are narrowing the gap between these children and young people and their peers.

The Board will annually update its work programme to ensure it keeps a focus on monitoring what is most important and actively drives the work of all partners in line with the priorities.

How we will achieve our three priorities

Priority 1: Improving outcomes from conception to 19 through good and outstanding universal services

Why is this important?

Early intervention and prevention is at the heart of this priority from the earliest years through to adolescence. Through places such as health settings, early years, schools, play and youth services, we help children and young people become resilient by supporting them to develop the foundations, aspiration and social and emotional capabilities that are highly significant for good outcomes. We make safeguarding everyone's business and this helps ensure that children are safe at home, at school and in the community. A healthy start in life and good early child development, healthy lifestyles, academic and social successes, good emotional health and skills to prepare for adult life help children overcome challenges they may face from time to time.

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we work
- hold universal services such as health services, Children's Centres, schools, play and youth services to account through challenge where necessary;
- support services to be judged as good or outstanding
- ensure that children achieve their full potential and are ready to move into the world of work.

As a **Catalyst**, we will focus on:

- strengthening the partnership between early years, health, schools and the third sector to drive outcomes for babies and young children and ensuring children are 'school ready'
- working with the Schools Forum, Education Improvement Strategy Group and the Islington Community of Schools to collectively drive and invest in quality and standards and improve outcomes in all schools and early years settings, through a culture of continuous learning and improvement;
- working through the Safeguarding Children Board to ensure that our safeguarding services are co-ordinated and as effective as possible;
- working with the Children's Service Improvement Group to ensure that all health services are working together and with partners to improve health and other outcomes for pregnant women, children and their parents
- strengthening the partnership between the providers of the adventure playground service
- encouraging greater collaboration across the youth sector both through the youth hubs and by organisations partnering to bid for and provide services
- bringing the world of work and learning together as a strong partnership between local employers, training, employment and education services, to enable young people to be ready for future careers
- exploring pathways for learning from the innovation of colleagues to ensure all partners are able to respond quickly to local need and build a community of support for all children and families

As a **Commissioner**, our 2015-19 priority Actions will include:

1. remodelling health services and children's centres to ensure that services for families from conception to a child's first birthday are effective and integrated (First 21 Months initiative);
2. targeted work that promotes access to health care and reduces health inequalities;
3. supporting the provision of health services in universal settings such as early years and schools

4. developing a sustainable model and balanced offer for early years and childcare that makes best use of resources and assets in Islington;
5. maintaining essential early years, pupil and school services in partnership with schools;
6. maintaining 12 adventure playgrounds to enable children's social, emotional and physical development and securing a different service delivery model for council-run adventure playgrounds
7. working closely with schools to ensure the effective use of the pupil premium;
8. commissioning youth work providers to co-produce programmes with young people that focus on young people's social and emotional capabilities;
9. commissioning youth work that maximises the resources available through asset maximisation, entrepreneurial approaches and commercial activity
10. introducing new information technology to better enable universal services to identify and refer children with additional needs
11. ensuring the workforce is suitably skilled to deliver effective interventions

Priority 2: Strengthening our early help support for children and families who have additional needs

Why is this important?

Stable families where parents are able to meet their children's needs and provide good care for them are good for children, families and the wider community. Families facing many disadvantages (such as low income, poor health and housing, domestic violence, parental mental and physical ill-health, parental substance misuse) are at greater risk of outcomes such as unemployment, school exclusion, anti-social behaviour and offending, with a large cost to society and a continuing cycle of disadvantage. With high local rates of child poverty; supporting parents and carers into work that means they are better off (both financially and in terms of their broader well-being) is the best route out of poverty. Duplication and lack of co-ordination are a poor use of resources.

We need to further develop our system of early help for families with multiple needs, ensuring access to the right services and support, delivered at the right time, in places where people can use them. Interventions need to be co-ordinated and targeted to ensure they bring about sustainable change, are proportionate to risk and reduce the need for treatment or statutory services. This will help to reduce what we currently spend on specialist services and enable reinvestment into services that prevent problems arising in the first place and get effective help to children, young people and families when problems first arise.

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we all work
- challenge services to deliver evidence-based early intervention and prevention, create a stronger evidence base, learn from what works locally and nationally and further develop a learning and improvement culture;
- promote services that focus on the most cost-effective way to prevent or address emerging issues of children, young people or their parents

As a **Catalyst**, we will focus on:

- working with partners to effectively address the needs of families with multiple needs and strengthen our partnership through our Early Help Advisory Group;
- working through the Education Improvement Strategy Group and Schools Forum on how best schools can contribute to this priority, particularly through the effective use of the pupil premium;
- ensuring effective early help services through the stronger families programme and Youth Justice Services Management Board.

As a **Commissioner**, our 2015-19 priority Actions will include:

1. maintaining the Community Budget for Families with Multiple Needs to:
 - enable parents to get pre-employment advice and support to improve the rate of parents in work;
 - enable parents to function without the need for continual support, strengthen their ability to address challenges and achieve greater independence;
 - support and challenge the most troubled children and families where there are young people with very complex difficulties, who otherwise may continue to offend or need to be taken into care;
 - integrate the expanded Stronger Families Programme into the community budget model, ensuring we can improve outcomes for younger children, families affected by domestic violence and health problems
2. commissioning re-evaluation of early help and implement the recommendations that will further improve outcomes achieved through early help
3. commissioning and implementing a new early help client database to give effective and efficient case recording and management oversight
4. supporting provision of health care in the right place at the right time and empowering children, young people and parents to be more in control of children's health, reducing the need for hospital admission;
5. ensuring effective integrated working with schools and other universal services through a 'Think Child, Think Parent and Think Family' approach using lead professional, early help assessment and the Team around the School/Team around the Child/Family arrangements, making best use of the Pupil Premium and other school resources.
6. maintaining a portfolio of effective parenting support programmes and within this, considering the need to improve engagement of fathers and male carers;
7. exploring the need for more effective programmes to enhance disrupted attachments in very early childhood (0-3years)
8. reviewing our Family Support and Early Help Strategies;
9. commissioning a co-ordinated network of providers to provide tailored contraception and sexual health support to avoid the use and costs of traditional sexual health services, unintended pregnancies and sexual health treatment;
10. providing timely and targeted youth support and implementing our youth justice plan to reduce reoffending, address the factors that contribute to it and also identify and manage the risk of harm to others and vulnerability
11. remodelling the young people's drug and alcohol service to improve early identification and prevention in universal and targeted services
12. maintain and strengthen early help parental substance misuse services
13. complete the development of a Parental Mental Health Service that delivers a coordinated offer of support and intervention across CAMHS, Adult Mental Health Services and Children's Centres, promoting resilience in users and the wider family
14. ensuring the workforce is suitably skilled to deliver effective interventions

Priority 3: Supporting our most vulnerable children and young people to be safe and thrive and to be able to overcome the challenges they face as they grow up

Why is this important?

Where children and young people experience trauma (including abuse and neglect), difficulties or stresses in their lives, we need to ensure that they have the effective support to overcome the odds and go on to achieve successful lives. For some children, particularly disabled children, children with Special Educational Needs, looked after children and children with long-term conditions, we have to work in ways that builds their social and emotional skills, enabling them to better recognise their strengths build resilience, respond to risks and challenges and take up opportunities that they recognise as important for their long term wellbeing

What will it take to do better through working together?

As a **Champion for children, young people and families**, we will:

- listen to what children, young people and parents tell us is important and using this to inform the way we all work
- ensure children are protected from significant harm and diverted from offending, gang violence and child sexual exploitation (CSE)
- ensure children overcome difficult and harmful childhood experiences
- ensure that all children looked after by the Council have the lives we want for our own children
- find permanent families for children who cannot live at home
- recognise children with long term conditions as vulnerable

As a **Catalyst**, we will focus on:

- Supporting the Islington Safeguarding Children Board and implementing strong quality assurance and workforce development systems to ensure that our safeguarding arrangements for children at risk are as effective as possible;
- Multi agency working and sharing of intelligence to ensure a better understanding of the prevalence and impact of radicalization, and the conditions that make radicalization possible;
- ensuring strong commitment of the local authority as corporate parent, and an integrated approach to planning and delivering services through the Corporate Parenting Board to ensure the best possible outcomes for Looked After Children;
- working through the Disability Strategy Board to ensure that the SEND reforms make a positive impact on the health and wellbeing of children and young people with disabilities and their families
- working through the Youth Justice Services Management Board with relevant agencies and services to ensure that offenders have effective support to reduce re-offending and improve their health, education, training and employment outcomes;

As a **Commissioner** our 2015-19 priority Actions will include:

1. implementing the education, health and care plan to support children with special educational needs and disability and their families in a more integrated and effective way
2. reviewing our commissioning arrangements through the North London Efficiency programme and Adoption and Fostering Consortium, to stimulate efficient and effective support for children looked after by the Council
3. reshaping services for children with complex health needs, mental health needs and disability in order to ensure a seamless transition from children's to adult's services
4. ensuring that our core business is protecting children in the community and those who are looked after and makes a real difference to children's lives
5. multi-agency working and sharing of intelligence to ensure children at risk of sexual abuse, including CSE and/or gang involvement are supported and protected
6. working with the courts, ensuring permanency is achieved within a timescale that meets the child's needs
7. ensuring the workforce is suitably skilled to deliver effective interventions

What we mean by Prevention, Early Intervention and Early Help

Being an Early Intervention and Prevention Place demonstrates the contribution all partners make to shift in spending towards early action that can result in building resilience, better outcomes and value for money.

Early intervention and prevention: Building resilience in individuals, families and communities so that they become more self-sustaining, protect children from harm provide stable and thriving environments resulting in less reliance on public services. There is a focus, however, on those that need direction and support and we, as an area, get in early and nip problems in the bud. Where this is not possible, we make early and authoritative decisions about permanent family based care.

Minimising risk of problems arising: The foundations for achieving the necessary outcomes and resilience at each life development stage such as good health, academic achievement and social and emotional capabilities. These tend to be the core business of universal services such as early years, health services, schools, play and youth services.

Key strategies: Children's Health Strategy; Child Poverty Strategy; Islington Safeguarding Children Plan

Early Help and Early Help Offer: our interventions, portfolio of evidence-based programmes, multi-agency systems and workforce to get in early and nip problems in the bud that keep children safe, supported and reduce the need for statutory services.

Key strategies: Early Help and Family Support Strategy; Children's Health Strategy; Islington Safeguarding Children Plan

Ensuring children with needs or problems that are serious or will endure can still survive and thrive: interventions to help individuals or families to treat, cope with or avoid the damaging consequences of problems or issues. These tend to be the core business of specialist intervention or statutory services such as children's social care or in-patient health care.

Key strategies: CAMHS; Corporate Parenting Plan; Islington Safeguarding Children Board (ISCB) Plan

Strategic Priorities – relevant extracts

The Children and Families Strategy is closely aligned with key strategic priorities across the Council and the key partnership boards.

Islington Commitment

- Making Islington fairer to create a place where everyone, whatever their background, has the same opportunity to reach their potential and enjoy a good quality of life by:
 - making sure there is access to quality training and education
 - working with businesses to create jobs and apprenticeships for local people
 - helping parents find affordable, flexible childcare
 - helping children through excellent local schools
 - supporting more vulnerable people to live healthy, happy, independent lives

Islington's Child Poverty Strategy

- Early intervention
- Improve life chances for children
- Sustainable employment for families
- Financial resilience

Islington's Child Health Strategy (LBI and CCG)

- Best start in life, prevention and early intervention
- Health services are high quality, cost-effective, clinically safe and deliver a positive experience of care
- All health services and partners working together to deliver care coordinated around the child or young person and the family for the:
 - acutely unwell child
 - those with long term conditions
 - those with mental health and emotional needs
 - those with special educational needs and/or disabilities

Health and Wellbeing Board strategic priorities

- Best start in life
- Improve mental health and wellbeing
- Preventing and managing long term conditions to extend both the length of life and quality of life and reduce health inequalities

Safer Islington Partnership Strategic Assessment

- Early intervention
- Violence against Women and Girls
- Tackling Gangs and Serious Youth Violence Strategy
 - Prevention and early intervention
 - Engagement and protection of young people at risk

Islington Safeguarding Children Board Plan

- Support the development of early intervention and oversee the review of its effectiveness
- Joint work with Adult services focusing on parents with learning difficulties and transition to adulthood
- Core business (child protection) focusing on domestic violence and neglect

Needs Assessment Summary

This summary provides key data and information about Islington's children, young people and families that has informed our Children and Families Strategy. More detailed needs assessment information on each of the below topics can be found in the Joint Strategic Needs Assessment (JSNA) on the Evidence Hub.

<http://evidencehub.islington.gov.uk/yourarea/jsna/Pages/default.aspx>

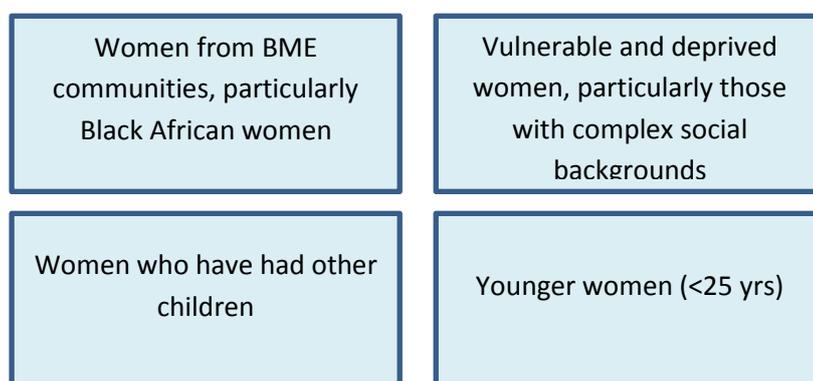
1. Local context

- Population size of 220,100. Islington is a small densely populated borough.
 - 2nd smallest borough in London in terms of geographical area
 - Highest population density in the country
- 14th most deprived local authority in country (2010 IMD - Index of Multiple Deprivation)
- 2nd most deprived based on IDACI (Income Deprivation Affecting Children Index)
 - Approximately 35% of children living in low income families
 - Almost 1/3 children in Islington live in a household where no one is working
 - 60% of families with dependent children live in social housing, compared to 20% nationally.
 - Most housing is in flats with no outdoor space; the borough has only 12% of its land designated to green space, significantly lower than the London average of 38%
 - 11% of households live in overcrowding (similar to London average)
 - Almost 30% of children and young people live in lone parent households – higher than national average.
- Approximately 43,500 0-19 yr olds living in 21,000 households.
- 66% of children and young people are from BME backgrounds, with a significant proportion with English not as their first language.

2. Early access to maternity services

The early stages of pregnancy are a key time in a baby's development and a mother's health. All women are encouraged to contact maternity services as soon as they are pregnant and especially before the 13th week (third month) of pregnancy. For the first quarter in 2013/14, 79% of women who gave birth in Islington were booked into maternity services before the 13th week. The average for 2012/13 (Q1-Q3. Q4 data not available) was 88%. This is below the target of 90%. Based on these figures, another 350-630 women would need to be booked into maternity services before the 13th week to meet the target.

Groups less likely to access maternity services before 13 weeks of pregnancy are:



3. Infant mortality (death of a baby before his/her first birthday, excluding still births)

- Islington's infant mortality rate is below comparators. However, infant mortality continues to be prioritised because of the link to deprivation.

4. A&E attendance

The rate of A&E attendance is highest for under 1s but is also high for under 4s. This is similar to other parts of London and higher than the national average. Approximately 25% of these attendances are avoidable, i.e. children do not require any treatment at A&E.

5. Breastfeeding

There is evidence that babies who are breastfed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity and diabetes.

- In Islington breastfeeding initiation in 2012/13 (89.5%) is higher than those for London (87%) and England (74%) and are also higher than most boroughs with similar levels of deprivation (2012/13)
- Prevalence of breastfeeding at 6-8 weeks (2012/13) is 75%, higher than greater London (70%) and England (47%).

Islington's breastfeeding rates are likely to be high because of the local demographic profile; with more women from ethnic minority groups who are more likely to initiate and continue with breastfeeding.

Research shows that ethnicity, social background and education are identified in patterns in which women are less likely to initiate and continue to breast feed. Younger women are also known to be more likely to give their babies formula milk rather than breast feed.

6. Immunisations

Immunisation take up has been increasing and very few children are now not fully immunised. This is higher than London and similar to England.

7. Oral health

Oral health contributes to general wellbeing and allows people to eat, speak and socialise without discomfort and embarrassment. Severe tooth decay in children can cause pain, disfigurement, infections, sleep deprivation, school absence and reduced nutritional intake and growth. Psychological impacts are significant too, including impact on self-esteem and confidence.

- Levels of oral disease in Islington children are relatively high with around 30% of 5 year olds suffering from tooth decay

8. Childhood weight and obesity

Child obesity has strong impacts on physical and mental health and emotional wellbeing.

- 36% of 10 year olds are overweight or obese (2012/13) and this is higher than the national rate
- Overweight children are twice as likely to become overweight adults compared to healthy weight children.
- The annual cost in Islington of treating diseases relating to overweight and obesity (across both children and adults) was estimated at £68.8 million in 2007, increasing to £73.6 million in 2015.

Overweight and obesity varies by gender, age, ethnicity and socio-economic factors.

9. Education

Children's education plays an important role in social mobility, health and wellbeing.

- 57.8% of children are achieving a good level of development (GLD) at EYFS
- 82% of children achieved level 4+ in Reading, Writing and Maths at end of primary school in 2014 and the % who achieved the expected progress between Key Stage 1 and Key Stage 2 was above comparators.
- 63.5% pupils achieved 5 GCSEs A*-C inc English and Maths in 2013 – above 2013 national and at Inner London averages.
- Qualification levels of 19 yr olds in 2013 slowly improving but significantly below the London and national average.
- Islington has seen an improvement in attendance. However, more progress needs to be made in this area.
- Children with high absence rates achieve substantially less well than their peers.
- The attainment gap between Free School Meal (FSM) eligible pupils and the rest is relatively small compared with the national position. However, our aim is to reduce this gap further.
- Achievement in EYFS was higher for White British group than Black or Minority Ethnic (BME) group in 2013. However, White British attainment was lower at GCSE.

10. Unemployment and NEETS

- 14th most deprived borough. However, at the same time, Islington has a much higher % of people employed in high-level managerial or professional jobs (43%) than London (34%) and England (28%)
- Highly qualified people (43% of Islington working age people have degrees) also constitute an increasingly high % of the employed population (75%) (ONS 2011 Census), up by about 23% in the last 10 years, compared with 58% in London and 41% in England
- Employment prospects for those with no or lower level qualifications seem to be getting worse – this group (25% of the population) represents an increasingly small % of those employed. This pattern is consistent with London and England
- Approximately 8% (about 12,500 people) of the working age population is claiming sickness benefits – a higher % than in any other London borough (DWP, Feb 2014)
- Over 50% of Islington's sickness benefit claimants are claiming due to mental health problems
- Employment rate is around 20-22% for people with long term health problems or disabilities, compared with 69-71% for those without.
- The Islington BME employment rate is consistently lower than that for the white population (ONS APS to December 2013).

Parents

- 29% of families with child dependents are workless. This is the highest % in London
- Parents face challenges to moving into work (eg. high childcare costs, lack of skills or work experience).

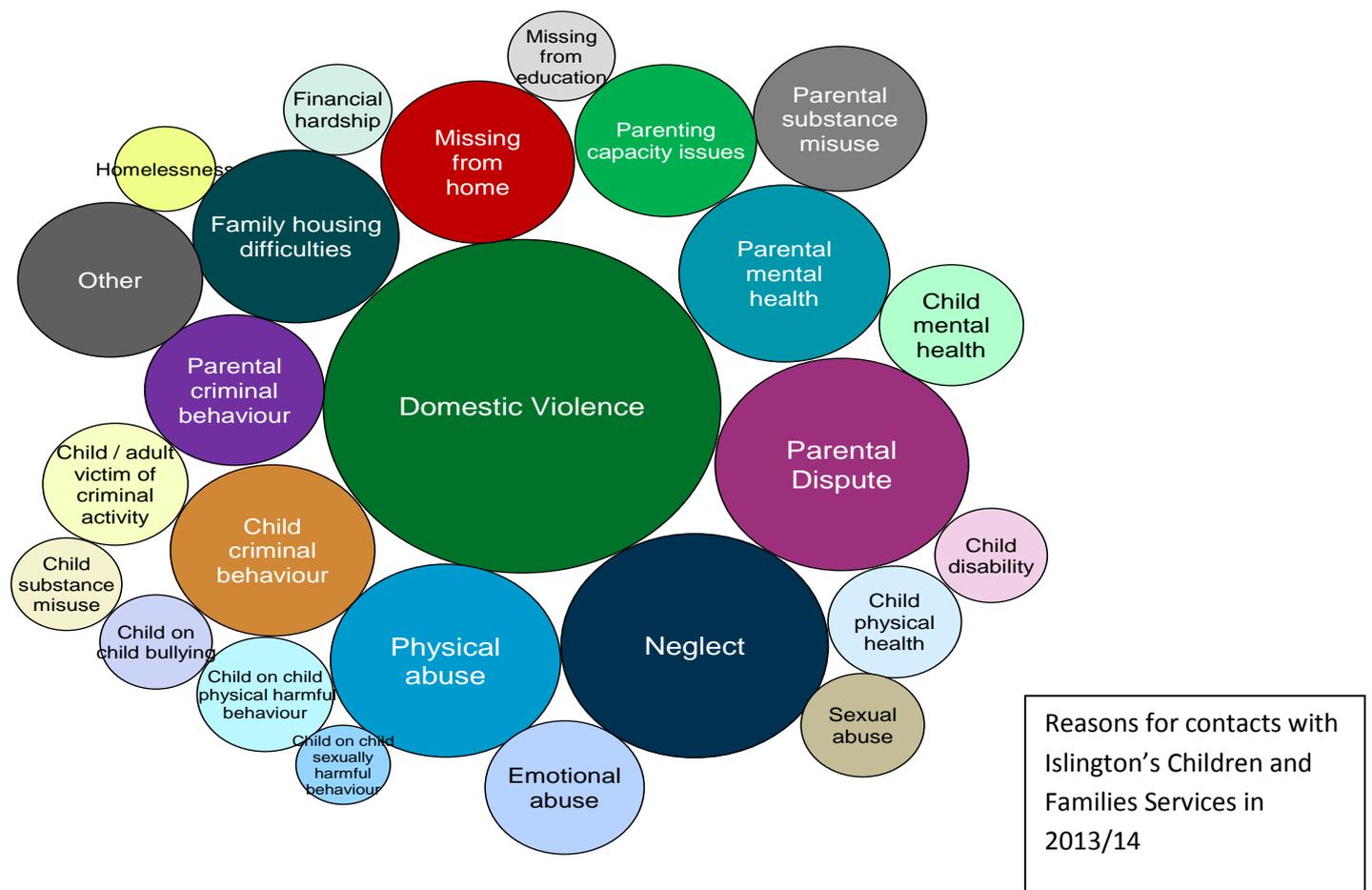
- 41% of households with dependent children in Islington are lone parents. Over half of these are out of work (2011 Census).
- 59% parents claiming out-of-work benefits have been doing so for over two years and 32% have been claiming for more than five (DWP, November 2013).

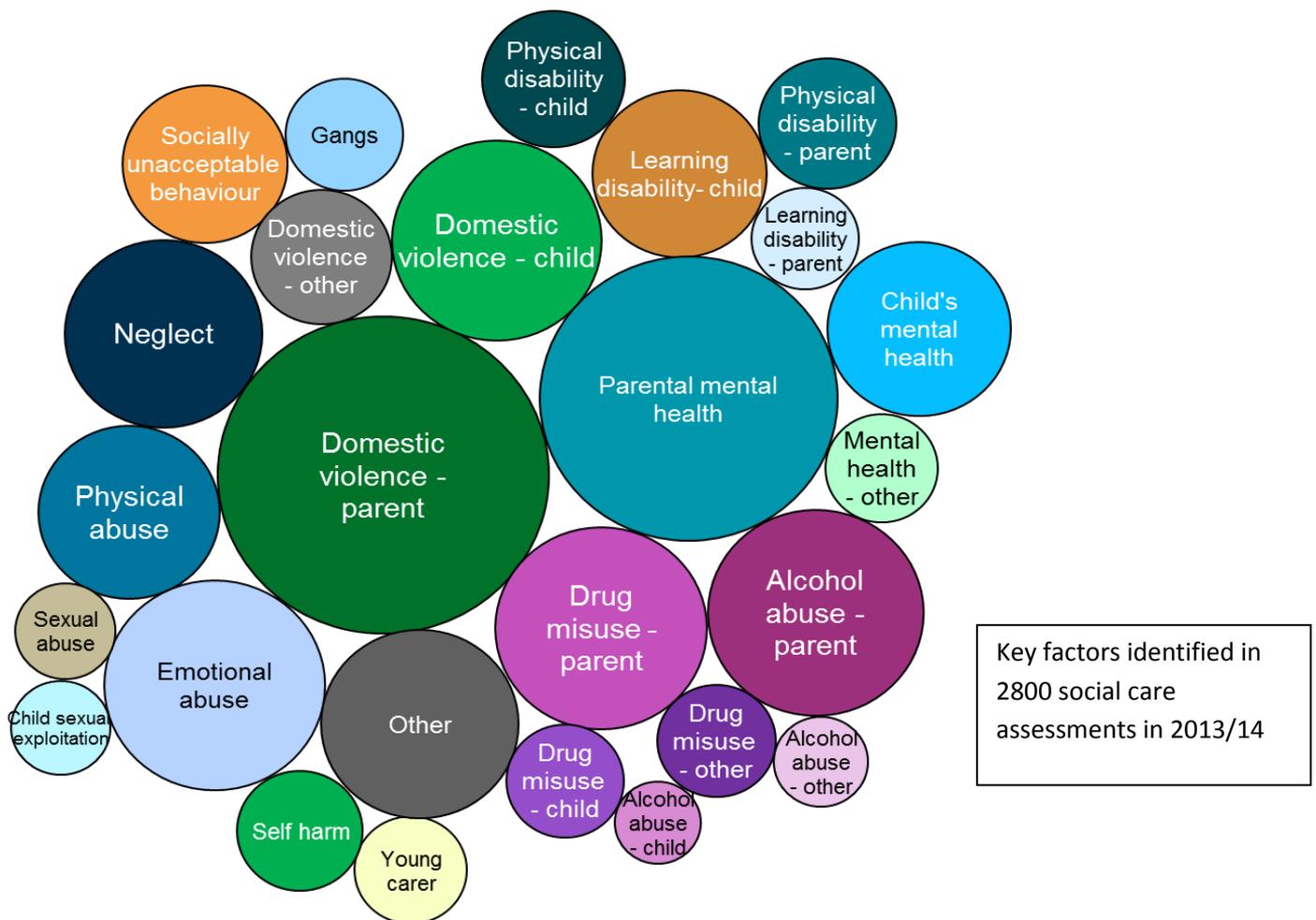
NEET 16-24 year olds

- 260 young people (5%) aged 16-18 in Islington Not in Education, Employment or Training (NEET), higher than the Central London average (3.7%)
- Almost all 16 year olds are in learning; engagement begins to fall at 17 and drops further by 18
- 1,010 young people aged 18-24 (4%) claiming Job Seekers Allowance (May 2014 DWP figures).

11. Vulnerability factors – parent; child/young person; environmental

11.1 Parental Vulnerability Factors





11.1.1 Domestic violence

Prevalence

- 3,806 incidents of domestic violence were reported to police in 2012/13, compared with 3,954 in the previous year. There were 1,571 offences of domestic violence (i.e. where the police found a crime had been committed).
- Islington has the second highest rate of reported domestic violence offences in North London. This can be an indication of higher violence and/or greater confidence in reporting to the police.
- 973 children were involved in an assessment where domestic violence was identified (including domestic violence involving parent, child or other)
 - 867 identified the parent being at risk
 - 348 identified the child being at risk
 - 156 where other members of the household were at risk
- 85% of perpetrators in Islington are men
- 1,700 children were affected by domestic violence in 2013/14 (referrals to children’s social care)
- Over the last 3 years, there have been on average 230 children each year in households that have been discussed at Multi-Agency Risk Assessment Conferences (MARACs)⁵

⁵ MARACs are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies.

As some domestic violence goes unreported, it is difficult to precisely judge the prevalence of domestic violence in Islington, or how many children are affected by the issue. Although domestic violence is present in a high proportion of referrals to both specialist and targeted services, we can assume that the true number of families affected is likely to be higher.

Impact

The physical, psychological and emotional effects of domestic violence on children can be severe and long-lasting. Witnessing domestic violence and abuse between parents irrespective of whether it results in direct physical harm to the child can have similar long term consequences for a child to physical abuse that is targeted at the child. A growing body of literature shows that children who have been exposed to domestic violence are more likely than their peers to experience a wide range of difficulties: Behavioural, social and emotional problems (i.e. become aggressive and antisocial/depressed and anxious); cognitive and attitudinal problems (i.e. Slower cognitive development and find it hard to concentrate in school) and long terms problems (i.e. More likely to become perpetrators (males) and victims (females) of domestic violence as adults).

There are a number of factors that may contribute to increases in future need:

- Welfare reform, unemployment and recession- Economic recession and high levels of unemployment may increase financial stress in relationships. Victims may feel unable to leave a partner on whom they are financially reliant.
- More victims may stay with the perpetrator because legal aid will not be routinely available in separation, divorce and child contact cases, or for non-British victims not on a spousal visa.

At risk groups include:

Women – nationally 80% of domestic abuse victims and similar in Islington

Transgender people – Up to 80% have experienced abuse in relationships

BME groups – populations from certain cultural backgrounds may be at risk of Female Genital Mutilation (FGM) or ‘honour’ based violence

11.1.2 Parental Alcohol and substance Misuse

Prevalence

There were 234 Islington adults who were receiving alcohol treatment in 2012/13 who were living with children, compared to 320 assessments by Islington Children’s Services where parental alcohol abuse was recorded.

Given the high level of substance misuse in Islington, it is likely to be that there are sizeable numbers of children living in households where this is a problem.

- 319 young people with at least one contact for parental substance misuse in 2013/14
- 727 assessments were conducted where substance misuse was identified. Of these:
 - 354 were for parental drug misuse
 - 110 were for another member of the household’s drug misuse
 - 367 were for parental alcohol abuse
 - 70 were for another member of the household’s alcohol abuse

Impact

The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children in both the short and long term (Social Care Institute for Excellence, 2005). The lifestyle of families with a substance-misusing parent can also be associated with a lack of routine, as well as social isolation.

Physical Impact	Psychological Impact	Socioeconomical Impact
<ul style="list-style-type: none"> • Maternal substance abuse: exposure to harmful chemicals and infection • Unmet basic needs (eg. food, hygiene, safety) • Lack of care and supervision: elevated risk of physical harm (eg. accident, fire) • Physical abuse • Induced substance misuse 	<ul style="list-style-type: none"> • Loss of attachment with the parent • Verbal abuse • Feeling insecure and anxious (eg. fears about discovery, being taken away or a parent dying; unpredictable behaviour of the parent) • Family break-up 	<ul style="list-style-type: none"> • Reversal of roles • Difficulties at school (eg. bullying, problems with concentration) • Financial burden (eg. unemployment, money to pay for drugs, substantial debts) • Social stigma/isolation, damaged social skills

11.1.3 Parental Mental health

Mental health conditions are common, affecting at least one in four people at some point in their life and one in six adults at any one time.

Mental health conditions account for the single largest source of disability and ill health in the UK.

Prevalence - parents

Islington has a significantly higher level of mental ill-health need than London or England. 15% of adults are experiencing depression or anxiety disorders in any week.

Applying the prevalence of parental mental health problems found in a high quality, large national survey of children aged five to 16, to the Islington population would suggest there could be as many as 6,000 children aged 5 to 16 in Islington whose mothers who would be classed as at risk for common mental health problems. Given that Islington has a relatively high proportion of lone parent families (just below 30% of children live in lone parent families), this may be an underestimate.

- 475 young people had at least one contact for parental mental health in 2013/14

Of all the assessments carried out by Children's Social Care in 2013/14:

- 872 children had an assessment where mental health concerns were identified. Of these,
 - 700 (27.7%) involved a concern about parental mental health
 - 101 involved a concern about another member of household's mental health

Impact

Children of patients with severe and enduring mental illness can experience greater levels of emotional, psychological and behavioural problems than their peers.

The National Child Development Study (NCDS), a national longitudinal study continuing since 1958, suggests that mental health problems in childhood can have an impact in adult life, including qualifications and employment, relationships and family formation, health and disability.

It is anticipated that the levels of mental ill-health will increase over the coming years as the current climate of long term austerity causes more financial hardship, unemployment and fears of destitution.

Self-harm has a number of physical and psychological effects. While the physical effects of self-injury might be obvious and harmful, the psychological effects of self-mutilation are no less damaging

Physical

- Wounds or scars
- Infection
- Nerve damage
- Broken bones
- Hair loss or bald spots
- Injury caused by overdose or poisoning

Psychological

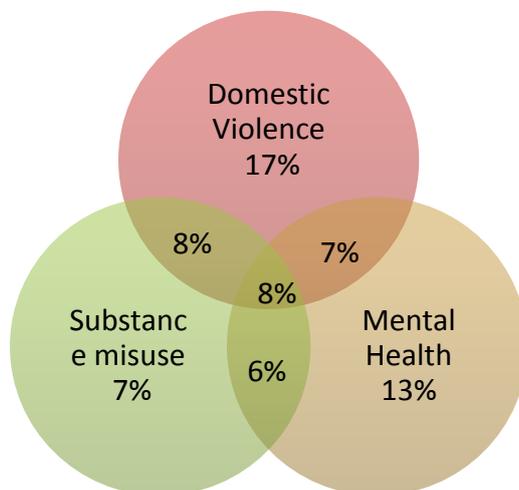
- Irritability
- Loneliness.
- Shame and guilt
- Stress and difficulty of lying to others / concealing about the self-injury
- Low self-esteem and self-hatred
- Depression
- Lack of control of self-harming behaviour

11.1.4 Key Parental Factors

The issues of domestic violence, parental mental ill-health and substance misuse have been identified as the most common features of families where harm to women and children has occurred.

Although a single issue such as mental illness may not detrimentally affect parenting capacity, there is considerable evidence that many parents also experience other difficulties (Cleaver and Walker with Meadows 2004; Velleman and Reuber 2007). It is the cumulative impact of combinations of factors that have been found to increase the risk of harm to children.

Intersection of key factors in Islington children's social care assessments, 2013/14



- 2/3 of assessments identified at least one of these three factors.
- 219 assessments identified concerns about all three factors
- 205 children (8%) were identified in assessments as being affected by all three factors.

11.1.5 Neglect

Prevalence

This is our biggest concern in Islington and is often affected by the three parental key factors, as listed above.

Of the assessments carried out by Children's Social Care in 2013/14:

- 47.5% of children (85) subject to child protection plans in 2013/14 were due to concerns regarding neglect.
- 763 young people with at least one contact to children's social care involved concerns about neglect (2013/14). Some had 2 or 3 contacts during the 12 month period.

Impact

Neglect has far reaching consequences and can affect all aspects of a child's development. It can have negative, long-term effects on mental and physical development. It can affect children's behaviour, educational achievement and emotional wellbeing.

Poor nutrition, poor hygiene and a lack of parental supervision can result in faltering growth, the development of medical conditions or the exacerbation of existing medical conditions.

Neglect can have dramatic effects on children's mental health. The emotional impact of neglect can lead to young people committing anti-social behaviour, self-harm and suicide. Some young people may seek care and affection from other people, which can put them at increased risk of sexual abuse and exploitation.

11.1.6 Family Stability

Prevalence

Although the proportion of children living in lone parent families across the country is around a quarter, this is a snapshot of all children at a single point in time. Looking to the future, 48% of all children born today will not be living with both natural parents by the time of their sixteenth birthday (Benson, 2010). This is not just about couples who divorce – unmarried families account for 80% of all break-ups.

In Islington, just under 30% of children were living in households headed by a lone parent (ACYPP Profile 2013). On average, around three thousand children are born to Islington parents each year. The research suggests that around over 1,400 of these children will not be living with both of their natural parents by the time they are 16.

Excluding information requests, parental disputes were the third most common reason for a contact to Islington children's social care in 2013/14, with 781 contacts for 686 different children and young people.

Impact

Children with separated, single or step-parents are 50% more likely to fail at school, have low self-esteem, struggle to make friends and with their behaviour. They often battle with anxiety or depression throughout the rest of their lives. Children who experience family breakdown tend to leave school and home earlier and report higher levels of smoking, drinking and other drug use during adolescence and adulthood (Centre for Social Justice, 2013).

Family breakdown is a key driver of poverty, especially for women, and half of all single parents are living in poverty (Jenkins, 2008). However, financial pressures can put additional stress on relationships and increase conflict, so family breakdown can be both a driver and an effect of poverty.

11.1.7 Parental Offending

Prevalence

Criminal parents are among the strongest family factors predicting offending (Farrington, 2011).

In Islington, 1,600 children and young people were living in a household where offending occurred (2012/13). This may not include families where there is a young offender, although offences may relate to older siblings who live at the household, rather than parents.

In 2013/14 there were 343 young people with at least one contact relating to parental offending.

Impact

Children of prisoners have three times the risk of antisocial/ delinquent behaviour compared to their peers (Murray and Farrington, 2008). 65% of boys with a convicted parent go on to offend compared with 22% of boys whose parents are not offenders (Farrington and Coid, 2003).

However, whilst there is a strong correlation, poorer outcomes are not proven to be caused by parental imprisonment (Ministry of Justice and Department of Children, Schools and Families, 2007).

Children of prisoners face barriers to educational attainment. Inflexible visiting times and long-distance placements mean that parents often have to take children out of school to visit their incarcerated parent. Emotional damage, separation, stigma and feelings of shame also impact on educational attainment. Research has also found bullying of offenders' children is common and this can lead to a child behaving antisocially or playing truant from school (Loucks, 2004).

Children of offenders are a hidden population and therefore it can be difficult to get services to them.

11.1.8 Parents with Learning Difficulties and Disabilities

Prevalence

Islington Housing and Adult Social Services hold a register of adults with global learning disabilities (around 750 at the time of writing). However, details on whether each adult is a parent are not recorded consistently enough to provide a valid estimate of prevalence.

In Islington's GP registered population there are 710 adults recorded as having a learning disability. Applying the 7% estimate obtained nationally, we can estimate that in Islington there are 50 parents with learning disabilities. It must be noted that there is a wider group of parents with learning disabilities whose needs fall below the threshold for support services.

There were 91 children had assessments by Islington children's social care in 2013/14 where parental learning disability or difficulty was identified as a key factor, much higher than would be expected from the national estimates.

Impact

People with learning disabilities are more likely to have other disabilities or certain other health problems, including mental health problems (Royal College of Psychiatrists 2008).

Children born to parents with a learning disability are at increased risk of inherited learning disabilities and psychological and physical disorders. Children of parents with learning difficulties may suffer neglect as a result of a lack of parenting capacity combined with a lack of support (McGaw and Newman 2005). It is recognised that parents with learning difficulties and disabilities are more likely to require financial, practical and social support.

11.1.9 Female Genital Mutilation and harmful traditional practices

Prevalence

The report *Female Genital Mutilation (FGM) in Islington: A Statistical Study* (2012) suggests given the background of some of the larger ethnic groups there may be a significant number of girls aged 0 – 18 at risk of (or who may have already undergone) FGM.

Impact

There are a number of possible immediate and longer term physical health implications of FGM as well as psychological/psychosexual implications (i.e. depression, anxiety, substance misuse and / or self-harm).

11.2 Child / Young Person's Vulnerability Factors

11.2.1 Young carers

Prevalence

- According to the 2011 Census, in Islington, 3.2% of young people (1,800 people under the age of 25, an increase from 1,515 identified in the 2001 Census) were providing some level of unpaid care to another person. A number of studies suggest this could be an underestimate, particularly in terms of young carers from Asian communities, due to a range of cultural and language barriers.
- The proportion of young people providing unpaid care in Islington is higher than the averages for London and England where 2.7% and 2.5% of young people respectively provide care.
- 30% of young carers provide 20 or more hours of care per week and a significant minority over 50 hours.
- There were 100 children in need assessments completed in 2013/14 where the fact that the child / young person had caring responsibilities was highlighted as a key factor.

Impact

Factors affecting young carers (according to Islington Young Carer's Strategy 2012-15):

- Adult mental health
- Substance misuse
- Disabilities
- Limiting lifelong illness

Young carers are affected by:

- stress, anxiety and feelings of guilt, interrupted sleep and physical injury
- performing 'adult' tasks; exposure to significant physical and/or emotional changes; transition into adulthood
- missing school, falling behind with work, feel unable to confide in teachers. Some young carers report feeling isolated from their peers and being bullied. National research suggests that 27% of young carers (aged 11–15) miss school or experience educational difficulties and 68% of young carers are bullied and feel isolated in school.
- putting other people first and can feel undervalued.
- lack a working parent and home finances may well be affected by disability. Reliance on young carers often continues into adulthood and may restrict choices as an adult.

11.2.2 Sexually transmitted infections

There were almost 1,300 diagnoses of acute sexually transmitted infections in Islington among 15 to 24 year olds in 2012, equivalent to a rate of 43 per 1,000 population. This is higher than the England average (34 per 1,000).

11.2.3 Teen parents

Prevalence

- The teenage pregnancy rate in Islington has fallen almost half from the 1998 baseline of 58.3 conceptions per 1000 girls aged 15-17 to 30.1 in 2012.
- This is higher than the London rate of 26 and England rate of 28.
- There are 92 conceptions per year to women aged under 18 (2010-12).
- Majority of conceptions under the age of 18 are unintended and in Islington almost two-thirds lead to an abortion, which is higher than the London and England average.
- The gap between Islington and the England and London rates has narrowed over time.
- There were 19 live births to Islington mothers aged under 18 in each of the last 3 years reported, with a rate which is below comparators.

Looked after children becoming teenage parents

Children who have been in care are almost 2.5 times more likely to become teenage parents (SCIE, 2004).

There are some risk factors that make looked after children more vulnerable to teenage pregnancy (Haydon, 2003), which include:

- Social exclusion and early sexual experiences: low levels of self-esteem and their desire to be included in peer groups making them more likely to conform with pressure to engage in early or unwanted sexual activity; sex perceived as a way of receiving love and affection
- Personal experience of abuse: distorted understanding about sex, sexuality and interpersonal relationships
- Pregnancy as a positive choice: parenthood as an alternative way to demonstrate their maturity and worth; stability and a sense of purpose or direction in their lives

Impact

Being a young parent in an area of deprivation can increase the risks and disadvantage for parents and children including:

- 25% higher low birth weight
- 60% higher infant mortality rate
- 3 times higher rate of post-natal depression
- By age 30, 22% more likely to be living in poverty than mothers giving birth aged 24 or over.
- Young fathers twice as likely to be unemployed at age 30 – even after taking account of deprivation
- 11% of NEET young people are teenage mothers or expectant mother.

Evidence shows that young people who experience high levels of disadvantage and vulnerability are at increased risk of becoming pregnant at a young age, perpetuating the cycle of deprivation.

11.2.4 Mental Health

Prevalence

- There are estimated to be over 3,000 Islington children aged 5 to 17 with a mental health disorder.
- The proportion of boys aged 5 to 17 diagnosed with a mental disorder (14%) was twice the proportion of girls (7%). It is estimated there will be 430 more children in Islington with mental health problems by 2021.
- 222 young people had at least one contact for child's mental health in 2013/14

Rates of mental health problems among children increase as they reach adolescence.

Mental health problems were most prevalent in children with a Black origin (14.5%), compared to those with White (13%) and Other (12%) ethnic origins, and least prevalent in Asian children (9%). The majority of children aged 5 to 17 with a mental health disorder are from a White ethnic group (largest population group).

Self-harm

In 2013/14, there were 133 children's social care assessments where suspected or actual self-harm was flagged as a key factor.

The Islington rate for hospital admissions due to self-harm amongst 10 to 24 years olds has been below the England rate, but above the London and Statistical Neighbour averages, 3-year average. These rates reflect an average of around 100 hospital admissions each year.

Impact

The emotional well-being of children is just as important as their physical health. Good mental health allows children and young people to develop resilience to cope with problems they may face as they grow up. The National Child Development Study (NCDS), a national longitudinal study continuing since 1958, suggests that mental health problems in childhood can have an impact in adult life, including qualifications and employment, relationships and family formation, health and disability.

Self-harm has a number of physical and psychological effects. While the physical effects of self-injury might be obvious and harmful, the psychological effects of self-mutilation are no less damaging

11.2.5 Children with long term conditions

Prevalence

The rate of emergency admissions for asthma, diabetes and epilepsy amongst under 19s for Islington registered patients fell from 675.0 per 100,000 in 2011/12 to 313.0 per 100,000 in 2012/13. The data for the 2013 calendar year shows that the rate has continued to fall. The Islington rate is now below the England rate, although it remains above the London rate.

Around two thirds of these admissions each year relate to asthma, and the rate of emergency admissions due to asthma is higher for Islington than for London or England. Although the rates for diabetes and epilepsy are lower, Islington children tend to stay in hospital longer than the national average when they are admitted in an emergency for these conditions.

Risk factors for asthma:

- Family history of asthma
- Nasal allergies, hayfever or eczema
- Exposure to tobacco smoke before or after birth
- Prematurity
- Early viral respiratory infections
- More males suffer from asthma than females
- Poor air quality

- obesity

Impact

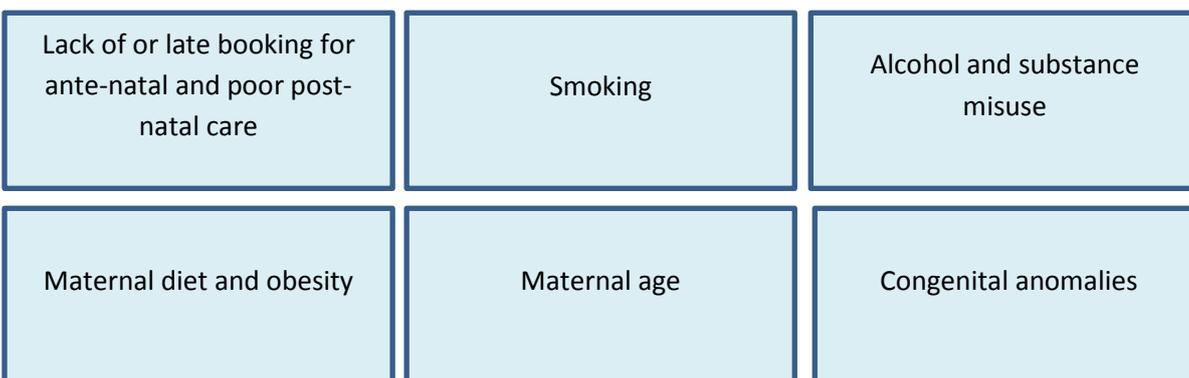
As well as the ongoing health risks due to these long term conditions, there are other effects on children and their families. Children and young people who have a long term condition are at risk of missing out on educational opportunities due to prolonged absences from school, either as a result of ill health or because of frequent attendance at clinics and hospitals

11.2.6 Children with Special Educational Needs and Disabilities (SEND)

Prevalence

- 24.5% of Islington school pupils have some form of Special Educational Needs, significantly above London and England (19%)
- Approximately 2500 (6%) disabled children in Islington in 2014
- Nationally evidence shows people with learning disabilities experience poorer health than non-disabled peers and have a higher risk of experiencing multiple comorbidities (additional condition occurring with a primary condition) including psychiatric disorders, and epilepsy
- Autistic Spectrum Disorder was the most prevalent need in 2013, followed by Speech, Language and Communication Needs and Moderate Learning Disabilities.
- Islington has a higher proportion of CIN with disability than statistical neighbours but similar to London average and lower than England average.
- In January 2014, around 5,800 children and young people aged under 19 in Islington had a Statement (843) or an additional educational need without a statement (5,080).
- There has been a slight rise in the number of children and young people with a statement over the past 5 years, equating to an average of 19 additional statements each year. However, there has been a slight decrease in the % of the total school roll compared to January 2013.
- About 75% of Islington pupils with statements are boys, similar to national picture.

Health determinants of SEN and disabilities include:



Impact

Pupils with SEND face barriers that make it harder for them to learn than other pupils of the same age. People with SEN also face poorer outcomes than their peers in terms of educational achievement, physical and mental health status, social and economic opportunities and transition to adulthood.

52% of child/children with a disability are living on low incomes, compared to the proportion in the whole population (39%).

The Children and Families Act (2014) introduced a new, single system from birth to 25 for all children and young people with SEN and their families. The Act extends the SEND system from birth to 25, giving children and young people with complex needs and their parents, greater control in ensuring that their needs are properly met.

11.2.7 Children with life-limiting conditions

Prevalence

In 2009/10 there were 147 cases of children with life limiting conditions. This was broadly in line with the London average of 34.9, but above the England average of 32.2.

The prevalence of life limiting conditions was associated with higher levels of deprivation and strong association with ethnicity: South Asian, Black, and Chinese, Mixed & 'Other' populations were statistically significantly higher compared to the White population.

11.2.8 Alcohol and substance misuse

Prevalence

Limited information is available on the usage of alcohol by children. The Islington hospital admission rate for under-18s with alcohol specific conditions has fallen in recent years, and has decreased at a faster rate than the London and England averages.

- Estimated prevalence based on national rates of drug use would indicate about 1400 children are affected.
- 131 young people with at least one contact relating to the child's substance misuse in 2013/14

Of all the assessments carried out by Children's Social Care in 2013/14:

- 4.2% (114) involved a concern about alcohol abuse by the child
- 2.3% (61) involved a concern about drug misuse by the child
- 727 assessments were conducted where substance misuse was identified. Of these:
 - 110 were for child's drug misuse
 - 59 were for child's alcohol abuse

Impact

Young people who persistently abuse substances often experience an array of problems, including educational difficulties, health-related problems (including mental health), poor peer relationships, and involvement with the youth justice system.

11.2.9 Offending

Prevalence

- Islington has seen a year on year reduction in first time entrants to the youth justice system with an overall decrease of 69% in the rate of first time entrants since the baseline year of 2007, but the rate in other local authorities has reduced faster.
- The reoffending rate, based on offences on the Police National Computer, for Islington offenders has been higher than the rate for any of the borough's comparators throughout the last 4 years.

- Islington's Youth Offending Team (YOT) worked with 285 young offenders during 2013/14.
- 13% of Islington's offending population over the last 3 years (2011/12 to 2013/14) have been female. This is slightly lower than the London (15%) and England (19%) averages.
- Based on a data matching exercise in October 2014 there were 312 households with someone accused of a youth offence between August 2013 to August 2014. There were 673 siblings living within these households. (Please note this figure does not include families with young people who were no longer living in the borough eg. they were in custody)

Gang activity

There have been reductions in Serious Youth Violence, Knife and Gun Crime since 2011, which has been attributed to the targeted enforcement, prevention and engagement work that has significantly disrupted what were three of the main gangs in Islington.

In 2013/14, there were 594 contacts to Islington children's social care due to the child's criminal behaviour. There were 113 assessments completed where the child may have been at risk of harm because of involvement with gangs.

Impact

There is considerable overlap between the risk factors for youth offending and substance misuse, and also with the risk factors associated with educational underachievement, young parenthood, and adolescent mental health problems. Action taken to address these risk factors therefore helps to prevent a wide range of negative outcomes.

Educational attainment:

Being in education, employment or training (EET) is one of the most significant protective factors in reducing the risk of reoffending. The proportion of young people supervised by Islington YOT who are engaged in EET has increased in the last two financial years and is above the rates for the borough's comparator group.

Accommodation

A higher proportion of young offenders in Islington (99%) are in suitable accommodation at the time their disposal is closed, compared to the borough's comparators. The proportion of Islington young offenders in suitable accommodation has increased in each of the last two years, whilst nationally, and across London as a whole, the proportion has been falling.

11.2.10 Children missing from home or care

A child is defined as missing from home/care 'if their whereabouts are unknown, whatever the circumstances of their disappearance' (Pan London Child Protection Procedures 2014).

In 2013/14,

- 27 children and young people went missing from care
- 35 children went missing from home (of which 63% were females)
- It is thought that around a quarter of children and young people that go missing are at risk of serious harm, with particular concerns around risk of sexual exploitation.

11.2.11 Children missing from education

In Islington a child is deemed missing from education when 'a child of compulsory school age, who are not on a school roll, nor being educated otherwise (e.g. privately or in alternative provision) and who have been out of any educational provision for a substantial period of time (usually agreed as four weeks or more) and who is not receiving a suitable education' (Department for Education).

- In the 2013/14 academic year, there was an average of 3 cases of Children Missing Education (CME) each month.
- CME are at significant risk of underachieving, being victims of abuse, and becoming NEET (not in education, employment or training) later on in life.

11.2.12 Child sexual exploitation (CSE)

Prevalence

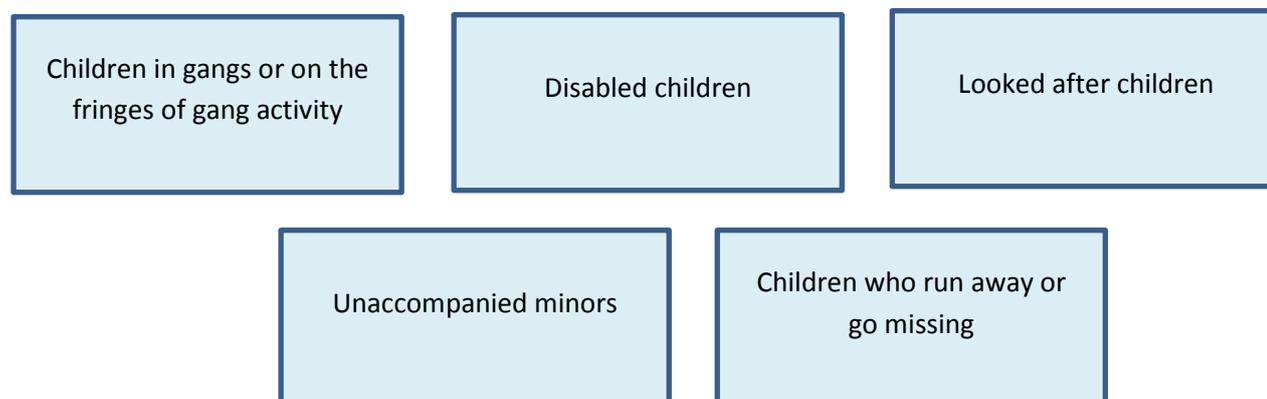
Child sexual exploitation is a type of sexual abuse in which children are sexually exploited for money, power or status. CSE is often hidden as victims may be confused or frightened and may not report it happening (NSPCC, 2013). Some young people are not even aware that they are being abused as they may be coerced into believing they are in a loving relationship, or that they are dependent on their abuser for protection (Sharp, 2011; Cockbain & Brayley, 2012; Child Exploitation and Online Protection Centre (CEOP), 2011).

- Referrals to children's social care rose from 3 in 2011/12 to 68 in 2012/13, to 96 in 2013/14. This is a significant rise in the number of CSE referrals and demonstrates the progress made in identifying and responding to CSE.
- However, as we know CSE is often hidden, we need to do more to identify children who are at risk or who are victim of CSE.

Of the assessments carried out by Children's Social Care in 2013/14:

- 2.9% of assessments identified concern about child sexual exploitation
- There were 77 young people where CSE was identified as a factor, leading to 68 Multi-Agency Planning (MAP) meetings (compared to 36 in 2012/13) to address concerns.
- 16 young people became looked after because of CSE in 2013/14.

Groups at increased risk of CSE include:



Impact

Impact on children and young people can include:

- Experiencing poor mental health
- Exhibiting higher levels of antisocial behaviour
- Increased likelihood of teenage pregnancy and substance misuse
- Educational underachievement

11.3 Economic and Environmental Factors

11.3.1 Poverty and low income families

Prevalence

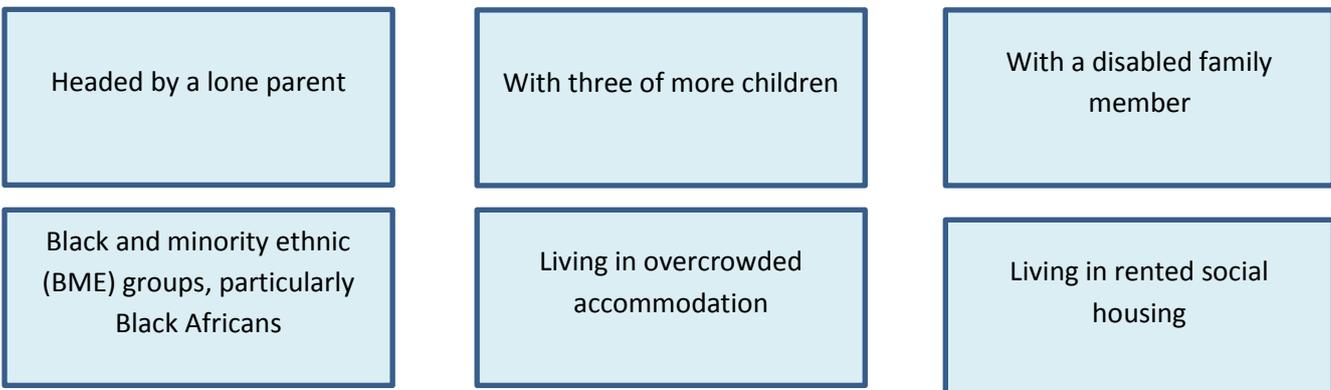
Islington has had the second highest proportion of children in low-income families in England each year from 2009 to 2012 (Tower Hamlets has the highest).

However, during this period, the proportion of Islington children in low-income families has fallen by almost ten percentage points, from 44 to 35%.

In 2012/13, approximately 4,600 in-work families with children received Working Tax Credit credits and Child Tax Credits (with approx. 8,300 children), as well as approximately 1,100 in-work families with children who received just the Child Tax Credits (with approx. 2,200 children).

A higher proportion of primary school age pupils in Islington are eligible for free school meals (FSM) compared to England as a whole. The proportion of Islington secondary school age residents who attend an Islington school that are FSM-eligible has increased over the last 3 years. Approximately 44% of all school children are eligible for FSMs in the borough.

Households over-represented in local child poverty figures are those:



Poverty is widespread across the borough with no clear spatial pattern. There is a strong correlation between those in poverty and those living in social housing.

Impact

The impact of welfare reform on child poverty is difficult to predict. However, the changes (ranging from the Household Benefit Cap, to reforms to disability benefits, to freezing annual inflation-based increases in the value of benefits) will reduce incomes for many workless families, especially those unable to move into work. This could entrench existing relative poverty and also increase levels of absolute and severe poverty.

The attainment of pupils who are eligible for Free School Meals:

Educational outcomes are lower for children from low income households and are affected by poverty from a very early age.

11.3.2 Population churn

Between 2009 and 2013 a greater number of families with children (of all age groups) moved out of the borough than moved into the borough.

Further work is being undertaken to establish the effects of population churn and the implications this has for cross borough work and for demand for services.

11.3.3 Housing at risk/temporary accommodation/overcrowding

Prevalence

- In July 2014, there were just under 6000 under 18 year olds living in an overcrowded household on the waiting lists to be rehoused by Islington's Housing service. This is approximately 13% of the resident population. There has been a slight fall in the number living in overcrowding compared to the same month in 2013.
- Just under 2000 Islington under 18 year olds were living in temporary accommodation, as of July 2014.
- There were over 1800 children were affected by the benefit cap in March 2013 and this has fallen by 61% to 700.

Fewer households were being affected by the cap in March 2014 due to the involvement of the local authority (Discretionary Housing Payments for example), amongst other factors. However, those still affected are amongst the most vulnerable and are often large families.

Impact

Poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood. Mental health issues such as anxiety and depression have also been linked to overcrowded and unfit housing. Bad housing affects children's ability to learn at school and study at home. Overcrowding is linked to delayed cognitive development, and homelessness to delayed development in communication skills. The lower educational attainment and health problems associated with bad housing in childhood impact on opportunities in adulthood.

11.3.4 Homelessness

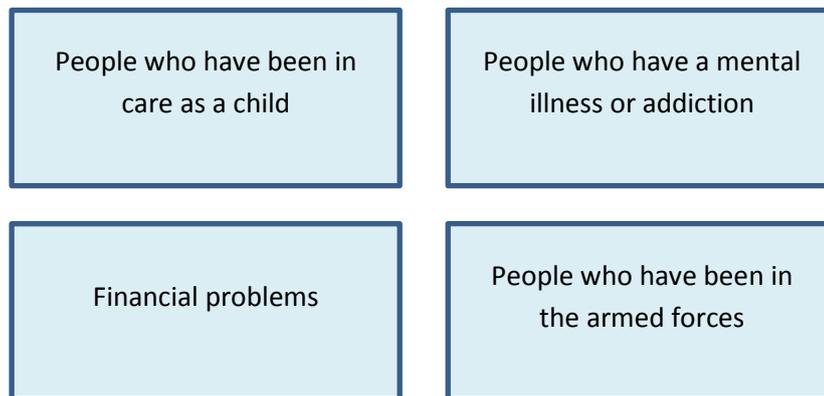
Prevalence

- Since the economic downturn in 2009 Islington has seen an increase in the numbers of people applying as homeless.
- 290 Islington households with dependent children or pregnant woman were accepted as unintentionally homeless and eligible for assistance in 2012/13. This represents a rate of 3.2 per 1,000 households, which is below the London average of 3.6 per 1,000.
- The main reason for which people in Islington make homeless applications is eviction by family or relatives.
- In 2011/12, 56% of households accepted as homeless had children or were expecting children.
- There has been a significant increase in the number of applications from young people, and from people with mental health issues.

Impact

Homeless children are three to four times more likely to have mental health problems than other children. Homeless children are two to three times more likely to be absent from school than other children due to the disruption caused by moving into and between temporary accommodation. Homeless children are more likely to have behavioural problems such as aggression, hyperactivity and impulsivity, factors that compromise academic achievement and relationships with peers and teachers.

At risk groups are:



Structural factors increasing the risk include:

- The impact of the welfare benefit system
- Shortage of affordable accommodation
- Unemployment
- Migration

Possible triggers include:

- Domestic violence
- Relationship breakdown
- Leaving home or care
- Unemployment
- Leaving institutions (e.g. hospital, prison)
- Lack of knowledge about benefits
- Getting into debt (particularly mortgage and rent arrears)

12 Children/young people in need of specialist and targeted services

The Department for Education define 'vulnerable groups' as 'disadvantaged groups', whilst Ofsted term vulnerable children among those who may need additional support or intervention in order to make optimum progress. There are a range of factors that make children vulnerable.

- Islington's Targeted and Specialist Children and Families Services have received around 12,000 contacts a year in each of the last five years (relating to 7,000 children a year). There were 6,422 different young people with a contact in 2013/14 (excluding information requests and Subject Access Reviews (SARs))
- Excluding contacts related to information requests, more than a quarter of the children for whom contacts were received in 2013/14 had at least one contact related domestic violence. The 'Other' reasons for contacts in 2013/14 cover 17 different reasons for contacts, including Child Sexual Exploitation (80 children) and harmful traditional practice, e.g. Female Genital Mutilation (23 children)
- Overall, 24% of these contacts progressed to a referral to children's social care, whilst 17% were referred to Early Help services.
- Most common referrals (over a quarter of cases) for early help in 2013/14 were for parenting issues, followed by housing issues, recorded in almost a fifth of all cases.

Children's social care assessments

Assessments were completed on over 2,400 children in 2013/14.

- The most common reasons for referrals to social care are abuse and neglect.
- Frequent parental characteristics are domestic violence, substance misuse and parental mental ill-health.
- The most common factor identified was where there were concerns that a parent (or carer) was subject to domestic violence.
- In 30% of these cases of suspected domestic violence there were also concerns that the child was also subject to domestic violence. On top of this, there are cases where the child may be suffering, or likely to suffer significant harm due to abuse (physical, emotional or sexual).

Children in Need

Children in need are defined as children with a disability or children where assessment shows they are unlikely to achieve a reasonable standard of health or development without provision of services

Islington has a higher rate of children in need (CIN) compared to statistical neighbours, Inner London and England. This could reflect that staff in partner organisations are well trained to identify child protection issues, are making appropriate referrals to children's social care, and so children are being kept safe.

- Islington had the 15th highest rate of CIN in the country, as at 31 March 2014.

Children on Child Protection Plans

- 179 children became the subject of a child protection plan in 2013/14.
 - 85 children (47.5%), this was due to neglect
 - 68 children (38.0%), this was due to emotional abuse
 - 25 children (14.0%), this was due to physical abuse
- The proportion of Islington children who became the subject of a child protection plan for a second or subsequent time fell between 2010/11 and 2012/13 to 10.4% but it rose in 2013/14 to 20.1%.

Looked After Children

- The number of children looked after by Islington fell between 2003/04 and 2008/09 and despite a rise between 2009 and 2013 the figure is now around 300 to 330 (similar to 2009 figure). The rate compared to the population is higher than statistical neighbours, inner London and England rates.
- 150 different children became looked after during 2013/14, although some of these children were looked after for more than one period during the year, so this reflects 158 periods of care.
- 54% of these children became looked after due to abuse or neglect, with the next most common needs being absent parenting (16.0%), family dysfunction (11.3%) and 'family in acute stress' (10.0%).

The majority of children looked after have needs other than for basic care and support with many exhibiting behaviours arising from attachment related issues or disorders.

- A higher proportion of Islington's looked after children population are placed out of the borough and more than 20 miles from home, compared to statistical neighbours, Inner London and England averages.
- There are more older young people (16+) becoming looked after
- There has been a fall in the number of unaccompanied asylum seeking children (UASC)

Educational achievement:

- Averaged out over the last 3 years, 52% of Islington children who had been looked after continuously for more than 12 months achieved level 4 or above in English and Maths (or Reading, Writing and Maths in 2013) at the end of Key Stage 2. This is higher than for looked after children

across the country but lower than their non-looked after peers (75%). Due to the change in the indicator in 2013, the comparator results are not available.

- Across the last 3 years, 18% Islington children who had been looked after continuously for more than 12 months achieved the benchmark of 5 A*-Cs GCSEs (or equivalent) including English and Maths. This is just below the Inner London average of 20%, but higher than the England average of 15%. Across the country as a whole, on average almost 60% of all pupils achieve of 5 A*-Cs GCSEs (or equivalent) including English and Maths so the attainment of looked after children at Key Stage 4 is lower than that of their peers.

Offending:

- A lower proportion of Islington's looked after children aged 10 to 17 who had been looked after for more than 12 months have been convicted or subject to a final warning or reprimand each year between 2009/10 and 2012/13 than the borough's comparators. The proportions reduced between 2009 and 2013 to 3.9% and were lower than England and Statistical Neighbour averages. Provisional data shows an increase in Islington 2013/14 to almost 10%.

Substance misuse:

- A higher proportion of Islington children who had been looked after for more than 12 months have been identified as having a substance misuse problem than the borough's comparators in each of the last 3 years. However, this may indicate that Islington has good processes in place to identify when a looked after child has a substance misuse problem.

School attendance:

- Local monitoring shows that in 2011/12, Islington school age pupils who had been looked after continuously for 12 months or more had absence levels of 5.0%. This is marginally higher than the Inner London and England averages (both 4.7%), but below the Statistical Neighbour average of 5.2%. However, only 5.7% of the Islington cohort were persistent absentees (pupils with an absence rate of 15% or more across the year). This is lower than the Inner London (6.0%), England (6.1%) and Statistical Neighbour (7.7%) averages.

Fixed term exclusions:

- 9.9% of Islington's school age pupils who had been looked after continuously for 12 months or more had a fixed term exclusion during the year. This is lower than the Inner London (13.0%), England (11.4%) and Statistical Neighbour (13.3%) averages. There were no permanent exclusions amongst Islington's school age pupils who had been looked after continuously for 12 months or more during the year.

Care leavers

Attainment:

- On average over the last 3 years the proportion of Islington's care leavers (children aged 19 who were looked after when they were aged 16) who were in education, employment or training has been in line with the borough's comparators. The percentage fall in 2012/13 actually represents a small number of young people. The difference was due to there being more young parents who were not in education, training or employment in the 2012/13 cohort compared to previous years. The number of young parents in the cohort was significantly higher than in previous years.

Accommodation:

- On average over the last 3 years, the proportion of Islington's care leavers (children aged 19 who were looked after when they were aged 16) who were in suitable accommodation has been in line with the borough's comparators.

Children of care leavers

- There is no local data available but research tells us that the children of care leavers are more than twice as likely to go into care themselves (Biehal *et al* 1995; Barn & Mantovani, 2007; cited by London Borough of Hounslow JSNA report, 2011).

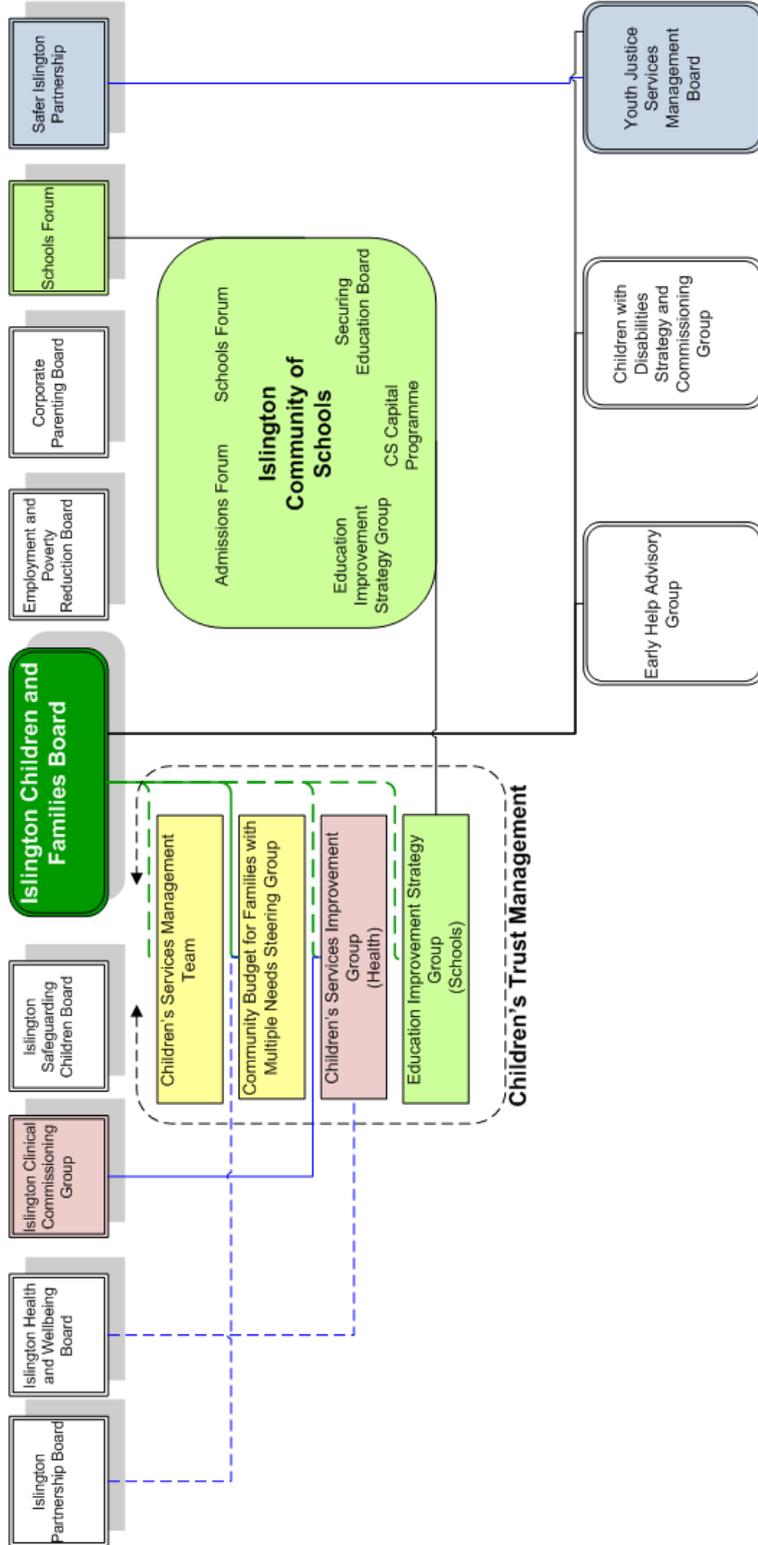
Sources:

Data and information used to produce this needs assessment summary has been taken from the following documents from the JSNA:

- Childhood immunisation fact sheet
- Childhood obesity factsheet
- Childhood oral health factsheet
- Child health strategy needs assessment
- Education and attainment fact sheet
- Early access fact sheet
- Infant mortality fact sheet
- Homelessness fact sheet
- Mental health fact sheet
- Special Educational Needs and Disability Needs Assessment
- Teenage pregnancy factsheet
- Unemployment and NEET fact sheet
- Vulnerable Children Needs Assessment
- Area Children and Young People's Partnership Profile 2014

Islington Children and Families Partnership

Islington Children and Families Partnership



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