Isle of Wight

Safeguarding Children Board

Annual Report 2014 - 15

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Foreword from the Independent Chair

I am pleased to introduce the Annual Report for the Isle of Wight Safeguarding Children Board 2014/15. I have now been in post nearly two years and would like to thank all organisations represented on the IOWSCB for their commitment, grip and engagement in making sure improvements continue to be made in protecting children from harm on the Island. During this reporting year 2014/15 the IOWSCB moved from a position where it was not meeting its statutory duties to a strategic partnership able to properly oversee how statutory agencies and partners are protecting the most vulnerable of children. In November 2014 Ofsted rated the IOWSCB as still 'requiring improvement' but meeting its statutory duties. Inspectors commented on the strong partnership across the Council, NHS organisations, policing, schools and the voluntary sector.

The findings from audits, data, serious case reviews and reporting schedules provided to the IOWSCB during 2014/15 have given me a clear view of how well child protection work is being managed. The information submitted to the Board gives me a picture of the pressure points across children's social care services, across NHS organisations, within schools and from policing. The IOWSCB has examined carefully the work that is being done to improve services and how best to ensure that those working on the front line, whether as social workers, police officers, health visitors, teachers or indeed any part of the children's workforce are part of the key learning and development. This has included actively listening to the voices of children, families, and the welfare of disabled children, and to the most vulnerable children in care. In particular, there has been a focus on making sure that all cases are properly managed, families are supported and information is exchanged between different services. The IOWSCB has concentrated on ensuring there is participation in safeguarding from all schools on the Island and GP surgeries, and that there is greater awareness of why some children go missing, don't attend school or are at risk of sexual exploitation or child abuse. All these issues remain priorities within next year's Business Plan but there will be a particular focus on children who are experiencing domestic abuse in the home, substance misuse problems or parental mental illness.

The IOWSCB is pleased to have established stronger links with the voluntary sector on the Island but there are still vacancies for lay members and it has proved difficult to recruit these important volunteer representatives on to the Board itself. A successful conference was held in September 2014 for many front line professionals working on the Island and this is to be repeated this year. We will launch another recruitment round for lay members before Christmas 2015.

There do remain some real challenges for organisations on the Island and it is vital that partner agencies focus on dealing with child protection matters robustly and through formal procedures. The two Serious Case Reviews published in this reporting year show the importance of professionals working together and understanding how to refer children for help where abuse or maltreatment is suspected. Everyone now knows the part they have to play in keeping children safe but intelligence provided to the IOWSCB during this year shows that problems still remain in information sharing between professionals, strong record keeping and providing help to the right children at the right time. The numbers of children coming into the child protection system on the Island remain disproportionately high and it is likely that confidence remains low amongst some teachers, doctors, police officers, health visitors and social workers in managing child protection matters.

As the child protection system on the Isle of Wight continues to be strengthened the IOWSCB hopes to see decreasing workloads for front line staff, more consistent decision making about what support children need across health, social care and the criminal justice system and continuing better relationships with all island schools. This engagement with education is fundamental and must include all establishments providing education to children including language schools over the summer period.

During the coming year the IOWSCB will continue to report on progress on the Island's improvement journey. Children's Services remain under government intervention and it is vital that the IOWSCB demonstrates through its partners that it has a strong grip and understanding of what is happening to all children on the Island to properly steer a better way of providing services.

Maggie Blyth

Safeguarding on the Isle of Wight: Context and Overview

The Isle of Wight has a land area of 380 square kilometres (146 square miles). Whilst the Island is predominantly rural (80% of the land), over 60% of residents live within the main towns of Newport, Cowes, East Cowes, Ryde, Sandown and Shanklin.

There are approximately 26,186 children and young people under the age of 18 years living on the Island. This is around 19% of the total population.

The population is growing less rapidly than the regional and national average. There is a significantly higher than average population of the 65+ age group, being approximately 24% of the island's population, and predicted to increase to 36% of the population by 2035.

The largest declines in population are 5 to 9 year olds, and 30 to 39 year olds. The highest growth is in the 60 to 69 age group and the 90 and over group.

Population and Demographics

Deprivation on the Island is lower than the national average. The Isle of Wight was ranked 126 out of 326 on the overall Indices of Multiple Deprivation 2010 (where 1 equals the most deprived). This position reflects a drop of eight places since 2007 (when the Island was ranked 134). In 2010, there were 5 areas on the Island among the 20% most deprived areas in England compared to 6 in 2007.

The Island is more deprived than the regional average, with the "South East" being one of the more affluent areas of England. The Island has 34 areas that fell within the 20% most deprived in the SE region. Further, 14 of these areas were amongst the 10% considered to be most deprived in our region.

The 2010 Indices of Multiple Deprivation show that the most deprived Island neighbourhoods are mainly in the town areas, although rural deprivation is experienced in terms of physical and financial accessibility, housing and key local services causing social isolation.

Although deprivation on the Isle of Wight is lower than the national average, child deprivation is in line with the national average, with about 21.1% (4,700) children living in poverty (IOW Health Profile 2014).

The proportion of children entitled to free school meals in primary schools is 18% (the national average is 18%), and in secondary schools it is 13% (below the national average which is 15%).

Children and young people from minority ethnic groups account for 5% of all children living in the area compared with 22% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British. The proportion of children and young people with English as an additional language is 3% in primary schools (the national average is 18%) and 2% in secondary schools (the national average is 14%). There are a small number of Travellers and a larger Eastern European population that seeks seasonal work in the agricultural parts of the county but who are not resident.

Safeguarding on the Isle of Wight: Context and Overview

Partnership Working

At the time of the last Annual Report in June 2014, changes made to the structure of the IOWSCB and the strategic partnership arrangement for Children's Services between the Isle of Wight and Hampshire Councils to improve Children's Services delivery were underway. During 2014-15 there have been additional developments in services for children.
Significant changes include:

- Introduction of the Multi Agency Safeguarding Hub (MASH) which works with the contact and referral service, providing triage and multi-agency assessment of safeguarding concerns was embedded.

- Revision of the Threshold document enabling practitioners to identify when children are best supported by universal, targeted or statutory provision.

- Restructuring of the Early Intervention provision through the newly commissioned Early Help service.

- Provision of an additional Child in Need team, and Independent Reviewing Officers within Children's Social Care, in response to additional safeguarding needs identified.

- Further development of St Mary's Hospital's Children's Safeguarding Team was implemented to include succession planning.

- Within Hampshire Constabulary additional provision for Children's Safeguarding Services, and re-structuring to enable further specialisation around children at risk of sexual exploitation as a 1 year pilot.

Vulnerable Groups of Children and the Journey of the Child

Multi-Agency Safeguarding

Responding to Safeguarding Concerns: Children's Reception Team (CRT), and the Multi Agency Safeguarding Hub (MASH).

"One of the most important things the council has done is to make sure that when people have a concern about a child that they refer ..... it is now responded to quickly and children receive the right help at the right time." Ofsted 2014

Key stages in a child's journey are the processes, assessments and decisions made at the Children's Services 'Front Door', where concerns about safety and wellbeing are raised through contact from partners or the public. This service has been continually improving on the Island since the previous Ofsted inspection in 2012 and the partnership with Hampshire County Council which started in October 2013. The MASH provides triage and multi-agency assessment of safeguarding concerns in respect of vulnerable children and adults, and decisions depending on statutory need, child protection or early help.

"The contact and referral service for the Isle of Wight and Hampshire is operating clear thresholds and is providing effective and timely response to referrals for children and their families. The multi-agency safeguarding hub (MASH) further strengthens the 'front door' through effective information sharing." Ofsted 2014.

The number of contacts to the CRT and the MASH, and the outcomes of these, have been closely monitored. Initially up to 80% of referrals to the MASH were screened out. This threshold was tested in the IOWSCB MASH audit in March 2015 which confirmed that thresholds were being applied correctly. There were an average of 1,214 contacts per month during the year, and 212 referrals on to the Children's Social Care Referral and Assessment Team.

During the year, 92% of the referrals from MASH to social care progressed to a children's assessment.

Where referrals to Social Care were initiated from

Agency	Q1	Q2	Q3	Q4	Total
Unknown	4	0	13	10	**27**
Police	176	158	208	155	**697**
Other Legal Agency	0	4	1	2	**7**
Court/ Probation	16	6	14	3	**39**
Other	64	65	52	58	**239**
Local Authority Service	43	72	38	50	**203**
Individuals	41	58	64	46	**209**
Housing	9	8	5	7	**29**
Health Services	103	73	75	46	**297**
Education	164	123	250	193	**730**
Anonymous	20	23	10	18	**71**
					2548

Vulnerable Groups of Children and the Journey of the Child

Children whose needs are being met through the Common Assessment Framework CAF) and Early Help Services

Children who do not meet the threshold for statutory Social Care provision are likely to have their needs assessed and met though the CAF process and Early Help Services.

The interface between Social Care and Early Help provision is critical when children transition between statutory and community based services. These arrangements have been the subject of improvement during 2014-15 following the IOWSCB Early Help Audit that took place early in 2014. The children's Threshold protocol was revised in April 2014 and re-launched formally by the IOWSCB at a conference in July 2014.

Early Help services have been in a process of continual improvement. Ofsted confirmed that the re-modelling of these services had been effective, and in particular that it has resulted in a clear focus on the child's strengths, and an improvement in collaboration between agencies.

The development of three locality "Hub" teams on the Island has started, with CAF support provided through each. Until the end of March 2015, the Children's Centres were managed by The Children's Society, Spurgeons and Furzehill Child Care Ltd on 8 sites on the IOW, had a registration rate of 93% and had 36,808 contacts with children during the year.

Barnardo's has been commissioned to deliver a fully integrated 0-19 Early Help Service from April 2015 including the national Troubled Families provision and Children's Centres. The vision for the new Early Help Service is that it will provide innovative interventions to meet the needs of the whole family, and that it will be able to demonstrate significant and sustained improvement to outcomes for children. Early Help Services, including family and parenting support and individual work with children, aim to prevent the need for escalation and reduce demand on social care intervention.

After attending a parenting course at a Children's Centre, a parent said in a TAF meeting:

"..there has been a lot less shouting following the course…I feel more confident to manage behaviours that I used to find difficult…I am confident, calmer and think things through before I act"

There were 486 CAFs open on 31 March 2015. This is an increase from 451 at start of the year. Of the 486 CAFs, 135 had been open for longer than 12 months. Ongoing quality assurance is in place for all cases approaching 12 months in Early Help. This is essential in checking the appropriateness of cases being held at the Early Help level.

During the year there was a significant reduction in the number of CAFs that "stepped up" to Social Care (for example a high of 45 in June 2014, and only 3 during March 2015). This evidence suggests that cases are being maintained at the appropriate threshold level. Professionals are reported to be making use of the Children's Reception Team for advice and guidance if they believe a case has further safeguarding concerns.

In the period January to March 2015 an increased number of CAFs were received, with the largest number of CAFs being "step downs" from Social Care (18).

Vulnerable Groups of Children and the Journey of the Child

Children in Need and Those Requiring Child Protection

Children "in need" are children who have been assessed (under s17 of the Children Act 1989) as being unlikely to maintain a reasonable level of health or development, or whose health and development is likely to be impaired, without the provision of services; or a child who is disabled. Children identified as being in need may have special educational needs or disabilities, they may be young carers, or be in need because they have committed a crime. It is the responsibility of the local authority to co-ordinate services through a single plan so that the family experience coherent support. The IOWSCB adopted a Child In Need strategy in May 2014 which describes how services will be provided to meet the needs of individual children and with clear expectations of all agencies to enable effective multi-agency working.

Where concerns are about maltreatment, and there is a risk that the child is likely to suffer significant harm, Children's Social Care must take action to protect the child and promote his or her welfare (S47 of the Children Act 1989). A Section 47 Assessment will be made and may result in a Child Protection Plan being established by the local authority to oversee provision from all relevant agencies. Children at risk of significant harm will have a range of needs, and may include those who are frequently missing from home, and those at risk of sexual exploitation.

The Ofsted inspection identified that although services were seen to be improving, the quality of practice at that time was not found to be consistent. The trend throughout the year on the Isle of Wight has been for significantly increased service demand within Children's Social Care. This picture is also reflected nationally. This increase has been a source of pressure on Social Care teams, and on-going scrutiny for the Board in relation to capacity to meet the need and risks identified. Initially it was thought that the increase in children assessed as requiring Social Care intervention was due to a backlog of children held inappropriately at CAF level. However, the number of assessments progressing to intervention has continued to increase, and is sustained by improved understanding of Thresholds and increased confidence in the process for responding to concerns as a result of the implementation of the Multi Agency Safeguarding Hub (MASH).

Capacity within Social Care has been adjusted to meet demand, for example by provision of an additional Child in Need Team in summer 2014. However, there are some areas where performance is weak, for example the timeliness of some assessments. A plan is in place to increase staff numbers to meet this challenge during the first part of 2015-16.

It is notable too that Hampshire Constabulary has increased its investment in Child Protection Officers in spite of cutbacks in other areas of the Police Force. An area of concern at the start of the year was the number of children identified as being in need who did not have an up to date Child in Need (CIN) Plan. This has been the focus of concerted effort for improvement. There was an increase from 37.9% in March 2014 to 90% on 31 March 2015, with a target of 100%.

Statutory Child Protection work has seen a large increase during the year, with children on a plan increasing from 164 to 264 children at the end of March 2015. There were 97 Child Protection Plans open 18 months to 2 years during the year. There were some delays for holding Initial Case Conferences which should take place within 15 days of the identification that the child is at risk. Additional Independent Reviewing Officers were recruited to meet demand.

The IOWSCB undertook an Audit into S47 cases. As part of this process children and their carers raised the need for improved communication between practitioners and children, and that children sometimes felt left out of the processes that social care were working to. In response to this young people have developed and delivered training to staff on how to engage with them, and a "Children and Young People's guide to services" is in production.

Vulnerable Groups of Children and the Journey of the Child

Children Looked After by the Local Authority

A child who is being looked after by the Local Authority is known as a Child in Care. In some cases a child will have been placed in care voluntarily by parents, in other cases Children's Services will have intervened because a child was at risk of significant harm. Children in care can be:

- living in accommodation provided by the local authority with the parents' agreement (section 20 of the Children Act 1989)
- the subject of an interim or full care order
- the subject of an emergency legal order to remove them from immediate danger
- placed in a secure children's home, or spending time in a secure training centre or young offender institution
- unaccompanied asylum seeking children

Children looked after may be placed with foster parents, they may be in a residential children's home, or they may remain at home with their carers under the supervision of the local authority.

Children in Care services have been under a lot of pressure during the year, and Ofsted requested that improvements were made. The number of children in the care of the Isle of Wight Council had been relatively stable (at around 195 children) until 2014/15. During this year, the number fluctuated, so that at the end of March 2015 there were 205 children looked after. This number continues to be significantly high compared to national figures and those of statistical neighbours.

Number of Children Looked After on the Isle of Wight by Age Group	
Age Group	**Count**
Under 1	9
1 to 4	32
5 to 9	33
10 to 15	74
16+	57
Grand Total	**205**

There was a notable increase in children aged 14 and over in the looked after system during the year. Children's Social Care are implementing intensive family support provision, with a focus on helping to stabilise the situation for children aged 13-16 who are at risk of entering care, or facing placement breakdown.

27 Children in Care on the island live with their parents. 72 children at 31/03/2015 were accommodated under section 20 (voluntarily with the agreement of parents). A number of children in care are accommodated off the Island in residential homes.

Vulnerable Groups of Children and the Journey of the Child

OFSTED Findings for Children Looked After by the Local Authority

Children in Care are subject to a care plan which co-ordinates the support that they need in order to thrive. Specific attention is paid to children's educational and medical needs. The data shows that in spite of pressure on staffing, the authority did relatively well during the year in terms of the quality of the plans, and meeting statutory requirements for Children Looked After Reviews, and this has been helped by the recruitment of additional Independent Reviewing Officers, who oversee management of the child's care.

'You were a tremendous support prior to our daughter's return home… we have had a great outcome and we are working well together as a family.' Quote from a parent (Ofsted Inspection)

Personal Education Plans for Children in Care are improving with oversight from the Virtual School for Children in Care; however educational outcomes for children in Key Stage 4 are poor. Concerns were raised by the Board in relation to the apparently low level of health and dental reviews undertaken, but revision of data has subsequently ensured that these are now approaching target levels, and that children's views have had an impact on the health services they receive.

During the Ofsted inspection in November 2014 it was acknowledged that significant improvement had been made but that elected members on the Corporate Parenting Panel needed further support to understand their role and the needs of looked after children. The IOWSCB will be undertaking an audit of Looked After Children Services during 2015/16 and this will feed recommendations to the Parenting Panel.

Ofsted's assessment was that provision for Children Looked After "Requires Improvement" but that progress had been made during the previous two years. It was noted that the children who are working on the Children in Care Council are doing great work to help services understand their needs, but that more support is needed to ensure that the views of a wider range of looked after children impact on the development and provision of services.

'She listens to my views and what I have to say. She can tell if I am in a bad mood, she gives me time to calm down before acting… She's a really good social worker.' (Ofsted 2013)

Vulnerable Groups of Children and the Journey of the Child

Care Leavers

Care Leavers are particularly vulnerable as they make the transition to adulthood. On the Isle of Wight a new service for young people leaving care was set up in December 2013. This team has raised the profile of Care Leavers and ensured greater continuity of provision and specialism. All Care Leavers now have a Personal Adviser, and Care Leavers have reported that this has made a big difference to them. The Board's Annual Conference "Adolescents at Risk" featured a case profile of a Care Leaver, and conference feedback indicated that this raised awareness among practitioners from agencies outside social care.

Two key issues in particular are monitored by the IOWSCB: housing, and the employment education and training (EET) status of young people leaving care. Nearly all care leavers appear to be appropriately housed at the end of the year. 66.7% of care leavers were in employment, education or training. The figure was nearly 75% in February and higher in parts of the year, with a target of 75%. There was a dip in care leavers in education, employment or training in March, due in part to some waiting to start apprenticeships.

Private Fostering Arrangements

Parents may make their own arrangements for their children to live with other families. These are Privately Fostered Children. The Local Authority must be notified of these arrangements. At the end of March, the Isle of Wight was aware of only 1 privately fostered child, where statistically it may be expected that there would be up to 30. The maximum number identified was 5 at the end of June. An action plan has been in place throughout the year to improve public awareness and the identification of these children. Private fostering has been a subject for consistent scrutiny by the Performance and Quality Assurance Subgroup and Public Health team. This work will continue in order to gain an understanding of the local picture, so that support and protection can be provided to the relevant children. An Annual Report on Private Fostering was received before this report is due to go to press and shows that the numbers are still very low. The IOWSCB will continue to monitor this very closely.

Children with a Disability

OFSTED reported that the Disabled Children's team was 'stable' and working well to safeguard children. The Short Breaks Service provides a range of activities for Children with Disabilities. Young Inspectors who consist of children with disabilities have audited these services in terms of quality and accessibility. It was noted that there is a need for further training in safeguarding of Children with Disabilities. The IOWSCB takes seriously the needs of children with disabilities and expects regular reporting on progress. The Disabled Children's Service has presented an Annual Report through the Performance and Quality Assurance Subgroup and this is a positive development.

Vulnerable Groups of Children and the Journey of the Child

Children Absent from School and Not in Education, Employment or Training (NEET)

Children who are excluded from school and those who have poor attendance are more likely to be vulnerable, and potentially their welfare is at greater risk than those who remain in continuous education. In June 2014 the Isle of Wight was subject to a re-inspection by Ofsted of the local authority arrangements for supporting school improvement. Ofsted judged the Island to be 'effective', but added there was a 'long way to go'. Engagement of the education sector with safeguarding is variable.

Inroads have been made with regards to pupil attendance and the secondary sector is closing the gap between its own and the national average percentage rate of attendance. In spite of this, no secondary schools are currently within the target of 96% and three are below the national average. Data for post 16 attendance is not a statutory requirement and the Board is currently reviewing this.

Attendance rates within the primary sector have improved and the Island now has a better attendance rate than that reported nationally. The IOWSCB has monitored attendance of children in care closely. The data on the attendance of Children in Care shows clear improvements since 2010, but the latest validated data for 2013 shows a 7.8% absence rate for these children. This remains higher than similar authorities at 4.2% and the national average of 4.4%. OFSTED inspectors raised the need to improve attendance for these children and it remains a clear focus for the IOWSCB for 2015-16.

Elective Home Education (EHE)

In April 2014, there were 200 children whose parents were choosing to provide an education for them at home. This is 1.5% of the school age population where the national average is 1%. Proactive work is undertaken to triage all home educated children with social care to identify possible risks. It is noted that the age at which much EHE commences is 14 or 15, an age where the children are potentially at high risk of child sexual exploitation. The IOW EHE policy was revised in January 2015 to include the safeguarding responsibilities of statutory agencies. This remains a challenging area of work since national legislation does not provide the local authority with many powers to affect change. The IOWSCB requires an Annual Report on children who are Electively Home Educated.

Children Missing from Education

When children who are on the school roll do not attend school and the carers cannot be contacted, the local authority has to try and find the child and if necessary identify them as missing on a national database. There are currently no concerns about the processes for tracking these children on the Isle of Wight, and Ofsted noted that arrangements for tracking and reviewing each case are robust. From September 2014 to March 2015, 74 children were recorded as missing from Education and of these, 7 were placed on a Section 25.

School Exclusion

Exclusion figures have been reducing. In 2013, they were broadly in line with national figures. The outcomes for 2014 show a further slight improvement in the number of days lost per pupil and the incidence of multiple exclusions.

Vulnerable Groups of Children and the Journey of the Child

Children who are Missing from Home and Children who are at Risk of Sexual Exploitation

The Hampshire Portsmouth, Southampton and the Isle of Wight 4LSCB Missing Exploited and Trafficked (MET) protocol outlines the practice that should take place to safeguard children and young people when there are concerns that they are at risk of abuse as a result of going missing, being exploited and/or being trafficked.

Whilst children go missing for a range of reasons there is always concern when they are not where they should be, and it is essential that any response to a missing child is timely, effective and proportionate. Child sexual exploitation (CSE) and Child Trafficking are child abuse, and all IOWSCB partners recognise that sexual exploitation is likely to have serious long term impact on the child's wellbeing. This led to a revision of local policy and this will be a focus for 2015-16.

Concerns were raised during the year that return interviews were not routinely completed, and that there were some communication problems between agencies. Practice around these concerns has been rectified and most children are engaging in return interviews.

Children with Mental Health Issues

The number of children referred to the Community Child and Adolescent Mental Health Service (CCAMHS) this year was 961 compared to 503 in the previous year which is a substantial rise. 54% were female, and 46% were males. The major referrers were the GPs who referred 420, Local Authority Schools and Social Care referred 113 and other referrals totalled 358. Just 10 cases were inappropriate and the remaining 951 cases were accepted. Some of these were assessed and some were seen through Team Around the Family meetings.

Maximum waiting times for routine tiers 1-3 was 12 weeks. Maximum waiting time for emergency tiers 1-3 was met with all seen within 24hrs. There were 78 young people admitted to the Isle of Wight paediatric ward, and five young people placed in mainland Adolescent hospital beds. Some of the young people had anorexia and other eating disorders, there were also cases of self-harm and suicide risk. The issue of anorexia nervosa is becoming more prevalent and since inpatient admissions can cause both the child and their family considerable distress and placements can be over 500 miles from their home, we attempt to work with them intensively to maintain their home, school and friends.

There were 79 attendances of young people at Accident and Emergency with self-harming behaviour. This was a slight decrease on the previous year (83 attendances). The majority of these children were previously known to CCAMHS. The IOWSCB has noted some concerns around girls presenting with eating disorders and is taking this forward in 2015.

Vulnerable Groups of Children and the Journey of the Child

Young People involved with the Criminal Justice System or who are at Risk of Offending

The young people who are involved with the Isle of Wight Youth Offending Team (YOT) often present with complex needs and require significant support. The YOT gets involved if a young person aged 10- 17 years:

- gets into trouble with the police or is arrested
- is charged with a crime and has to go to court
- is convicted of a crime and given a community or custodial sentence

The YOT team look into the background of the young person and try to help them stay away from crime. The Isle of Wight YOT works by:

- running a Youth Crime Prevention Service - this was set up in September 2014; the service uses diversionary activities to reduce the number of young people formally entering the youth justice system
- helping young people at the police station if they are arrested
- running a Youth Caution Clinic at the Police Station fortnightly to see if the young person who has been cautioned needs signposting to other services
- helping young people and their families at court
- supervising young people who are serving a community sentence
- staying in touch with a young person if they are sentenced to custody, and providing support when they leave

The YOT has continued to see the number of young people they work with decrease from previous years. First Time Entrants to the Youth Justice system continued to decrease during the year, with a figure of 583 entrants during 2014/15. This shows positive progress and is well within the target of 660 that was set for the Island this year, but is still higher than the national figure.

The level of re-offending by young people on the Island has been disappointing at 48% against the target of 42%. We need to take into account that this was a time when Children's Services on the Island including the Youth Offending Service were transitioning to new arrangements. During the year, the YOT's involvement in the Youth Justice Board's Re-Offending Project has resulted in the development of an IOW YOT Re-Offending Action Plan, which will focus efforts to reduce the level of re-offending in the coming year.

This latest reporting period of January to December 2014 indicates a significantly higher level of custodial sentencing compared to the equivalent period in the previous years. There were 14 custodial sentences during the year, equivalent to 1.14 per 1,000 young people aged 10-17. The Island's custody rate is double the national figure and three times the average for statistical neighbours. Scrutiny and analysis by the YOT in relation to the high number of young people receiving custodial sentences is ongoing with a report back on key lines of enquiry scheduled for the July 2015 Local Management Board. A multi-agency approach will be required to reduce this area of concern.

In the second quarter the YOT underwent a Short Quality Screening inspection. Inspectors praised pre-sentence reports and engagement work. Areas identified for improvement were planning, vulnerability and risk of harm. The general trajectory from this inspection was one of improvement.

Vulnerable Groups of Children and the Journey of the Child

Children living in families where Domestic Abuse is present

Ofsted highlighted the need for the IOWSCB to do more to understand the prevalence of domestic abuse for children on statutory plans, and to respond to the links between domestic abuse, substance misuse and mental health needs in adult carers. Monitoring by the Board on the prevalence of domestic abuse in families where children are on a child protection plan indicates that domestic abuse has been prevalent in between 50 and 60% of cases during the year. The IOWSCB Section 47 Audit identified missed opportunities to refer families to the Multi Agency Risk Assessment Conference (MARAC). Actions are in place to improve practice in this area and the report from MARAC early in 2015 indicated that both referrals and social care attendance at the MARAC had improved.

The Board's focus on the prevalence and impact of the "Toxic Trio" (domestic abuse, parental mental health and parental substance misuse) will continue into 2015-16 as the theme for the annual IOWSCB Conference and training for practitioners, as will the drive to engage Adult Services more routinely in child planning meetings. Funding has been secured by Children's Social Care from the Department of Education's Innovation Fund to support the introduction of Family Intervention Teams in 2015/16. This will focus on work with families impacted by the Toxic Trio to reduce the risks to children.

72 people attended a total of three IOWSCB training sessions on the impact of domestic abuse on children during the year, and Ofsted noted that social workers appeared to have benefited from training on the impact of domestic abuse.

Children at risk of Forced Marriage, and Children at risk of Female Genital Mutilation (FGM)

In December 2014 the IOWSCB requested initiation of a Task and Finish group to review partner awareness and actions with regards to forced marriage and FGM. This work has been led by Public Health and through a thorough consultation a comprehensive strategy including fact sheets for practitioners has been developed and will be approved by the Board soon after publication of this report. The Hampshire Police held a conference on FGM to raise awareness of this important issue.

Statutory and Legislative Context for LSCBs

Role of Local Safeguarding

Local Safeguarding Children Boards are statutory bodies. They were established by the Children Act 2004 (Section 13) and the Local Safeguarding Children Board Regulations 2006. The objectives of LSCBs are set out in Section 14 of the Children Act 2004:

- To co-ordinate what is done by each person or agency represented on the Board to safeguard and promote the welfare of children in their area; and
- To ensure the effectiveness of that work

The work of the Board is governed by the statutory guidance Working Together to Safeguard Children 2013 (amended in March 2015), which sets out how organisations and individuals should work together to safeguard and promote the welfare of children.

Safeguarding and Promoting the Welfare of Children

The Government's definition of Safeguarding and promoting the welfare of children is “That children are protected from maltreatment; that their health and development are protected; that action is taken to ensure that children grow up in circumstances where they have safe and effective care, and that children have optimum life chances and to enter adulthood successfully.” Working Together to Safeguard Children (March 2015)

Statutory and Legislative Context for LSCBs

The Isle of Wight Safeguarding Children Board (IOWSCB)

The Isle of Wight Safeguarding Children Board is independently chaired, and consists of senior representatives from the principle stakeholders. The Board is collectively responsible for strategic oversight of safeguarding arrangements: it does this by leading, co-ordinating, challenging and monitoring the delivery of safeguarding practice by all agencies across the Island.

The approach of the Board is underpinned by two key principles:

Safeguarding is everybody's responsibility - for services to be effective each professional and organisation should play their full part.

A child centred approach - for services to be effective they should be based on a clear understanding of the needs and views of the individual children whilst recognising the support parents and carers may require. The Board is committed to involving children and their families in its work.

Vision

"Working together to ensure high quality outcomes for all children, young people and their families and to enable them to access sustainable support and services"

This Vision is shared with the Children's Trust Board, the Health and Wellbeing Board (HWB) and the Isle of Wight Council.

"..the LSCB is now in a stronger position to undertake the oversight, scrutiny and development of safeguarding work.." (Review of the effectiveness of the Isle of Wight Local Safeguarding Children Board, Ofsted; November 2014)

The Board's focus for the reporting year 2014-15 as outlined in its Business Plan was:

Children get the right service at the right time with appropriate and timely interventions offered when children are suffering harm
How will we know if we've made a difference: *We will be confident that the children subject to intervention are the right children with the right plan, and more families are supported to care for their children at home*.

We continually learn from what we do
How will we know if we've made a difference: *We can demonstrate outstanding practice in safeguarding children and young people and our collaborative strategic planning is evidence-based taking account of current performance*.

We know vulnerable children and young people feel safe
How will we know if we've made a difference: *Children and young people tell us they feel safe and supported in their home, in their school and in their local area.*

We make it easier for practitioners to work effectively together
How will we know if we've made a difference: *Staff tell us they feel supported to develop their skills and practice and that the right training is provided to meet their need.*

Statutory and Legislative Context for LSCBs

Isle of Wight Safeguarding Children Board Information and Guidance

The IOWSCB has worked hard to develop effective communication systems to enable practitioners and the public to access information and guidance.

Website

The IOWSCB website was relaunched in 2014 and contains information and guidance for parents and practitioners on a variety of safeguarding subjects i.e. bullying. It also contains policies, links to national legislation and other helpful websites. Data shows that over 5,000 people used the site, and many of these returned to use the site again during the year. Feedback about the website has been very positive, with many saying it is useful and simple to use.

IOWSCB Newsletter

The newsletter is generated quarterly and contains decisions taken at Board meeting, news and information from the IOWSCB as well as links to websites and documents. This has been well received by practitioners
"Thank you for sending us the newly developed newsletter. This is a really excellent way of communicating with stakeholders and anyone who is interested in the work of safeguarding on IOW"

Twitter
The IOWSCB Twitter account (@IOWSCB) was started in July 2014 to share current articles and up to date news reports on safeguarding related issues.

Day to day, the work of the IOWSCB includes:

- Undertaking multi-agency thematic audits and partnership reviews into the effectiveness of services. In 2014/15 this included audits in relation to Neglect, Section 47 Assessments, Child Protection Arrangements and the effectiveness of the Multi Agency Safeguarding Hub (MASH);
- Ensuring that effective data is available so that we can be clear on the needs of children and the priorities in relation to improving safeguarding in our area;
- Overseeing the training and learning opportunities that are available for the children's workforce, and reviewing the effectiveness of these;
- Managing the completion and publication of Serious Case Reviews, and ensuring that the learning from these improves services in practice;
- Ensuring that partners are fulfilling their statutory obligations in relation to safeguarding and promoting the welfare of children

The IOWSCB has the following Sub Groups, which meet regularly throughout the year:

- Business Management
- Performance & Quality Assurance
- Serious Case Review
- Missing, Exploited & Trafficked
- Education & Schools
- Workforce Development

Governance and Accountability Arrangements

Local Partnership and Accountability Arrangements

The Board's Independent Chair is directly accountable to the Managing Director of the Isle of Wight Council and works closely with the Director of Children's Services. The strategic partnership arrangement for children's services which was introduced between the Isle of Wight Council and Hampshire County Council in October 2013 is now well established. Close liaison is maintained between the Independent Chair and Hampshire Constabulary and the Police and Crime Commissioner, the Council's executive member for children's services and the Chair of the Health and Wellbeing Board on the Island. Moreover, the Independent Chair will maintain a close relationship with the Island's CCG and NHS Trust.

During the year, and in response to the Ofsted inspection, the IOWSCB is pleased to have strengthened representation from the wider voluntary sector, law enforcement agencies and adult services. The Voluntary Sector Forum on the Island has elected representatives that sit on the Board and all of the subgroups.

Ofsted had queries about the lack of engagement between the IOWSCB and the Family Justice Review Board. The Independent Chair and the Board Manager met with members of the Family Justice Review Board to develop the memorandum of understanding for both the Hampshire Safeguarding Children Board and the IOWSCB which clearly describes how the two Safeguarding Boards will link with the Family Justice Review Board in 2015-16.

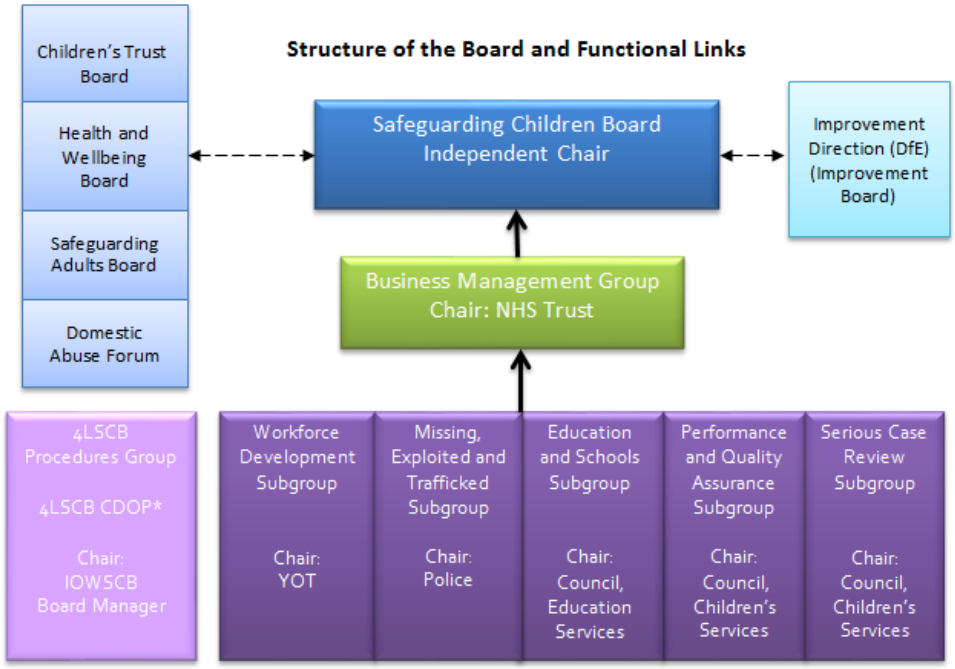
The Board works closely with the Local Safeguarding Adult Board and Domestic Abuse Forum on areas such as substance misuse, domestic violence and parental mental health. A protocol was agreed with these strategic partnerships and the Health and Wellbeing Board in 2014 to clarify responsibility and accountability between the Boards, and to align priorities and make best use of resources.

A Children's Improvement Board was set up in 2013 and met on a monthly basis. This had an Independent Chair and worked to improve services following the OFSTED Inspection. The Board officially stood down in March 2015 and the LSCB was committed to maintaining improvements.

"We believe that now is the right time for the LSCB to take forward the role of oversight and challenge, skilfully carried out by the Children's Improvement Board Chair" (Department for Education)

Governance and Accountability Arrangements

Board Structure



This year the IOWSCB has developed its own Workforce Development Subgroup which now exists independently of the Hampshire Safeguarding Children Board.

Following the Ofsted Inspection the Isle of Wight has decided to develop its own Child Death Overview Panel (CDOP) as part of the Serious Case Review Subgroup. This will be in place from November 2015, whilst retaining some partnership working with the other members of 4LSCB (Hampshire, Portsmouth and Southampton) ensuring a trends analysis is done across the wider area.

Financial Report

The IOWSCB was successful in securing a Police and Crime Commissioner grant of £8,000 to enable us to deliver 'Chelsea's Choice' to Secondary Schools across the island. The play explores Child Exploitation.

Total contributions remained similar to previous financial years but included a brought forward balance of £86,005 from prior year underspends which dealt with one off pressures in 2014-15 and also contributed to setting up a SCR reserve. The cost of running the IOWSCB was fully met from this budget and the £13,224 underspend is ring-fenced in the partnership budget for utilisation in 2015-16.

2014-15 Budget Summary as at 31st March 2015

	Agreed Budget Plan (£)	Actual (£)
INCOME		
Contributions from partners	164,323	164,323
Prior year carry forward	86,005	86,005
Other income	8,000	8,000
TOTAL FUNDING	**258,328**	**258,328**
EXPENDITURE		
Training & Conferences	27,500	39,113
Communications	1,000	1,060
Administration	5,981	5,240
Serious Case Reviews	20,000	26,839
SCR Reserve	0	40,000
Other Consultancy	0	4,540
CDOP Contribution	8,550	8,550
Independent Chair	21,600	23,148
Staffing	87,692	96,615
Unallocated carry forward	86,005	0
TOTAL EXPENDITURE	**258,328**	**245,104**
NET EXPENDITURE (INCOME)		**13,224)**

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

Single and Multi-Agency Training Provision

Level 1 and 2 Safeguarding training is provided across the children's workforce by the Council's Workforce Development Team. Training uptake is monitored through the Performance and Quality Assurance Subgroup.

The IOWSCB runs Levels 3 to 5 training as well as a programme of training and events (including the Board's Annual Conference) to meet specific areas of need identified through Serious Case Reviews or audits.

The Board's Annual Conference this year was around the theme of Adolescents at Risk. This was a successful event attended by 155 people, with significant attendance by the entire partnership and in particular the NHS Trust and the Voluntary Sector.

Comments from Conference Attendees:

"Extremely good- invaluable"

"Really high quality event… Inspiring speakers"

"Thoroughly informative and thought provoking"

"The best Safeguarding Conference I have attended"

"Chelsea's Choice was incredible"

The table below illustrates the training, workshops and conferences provided by the Board in 2014-15:

Training Course	Date	Number of Attendees	% Rating of Quality
Child Trafficking	Sept 14, Nov 14, Feb 15	124	n/a
CSE	Sept, Oct, Nov 14	119	79%
Child Protection Training	May 14	38	n/a
Child Protection Training for Managers	June, July 14	37	n/a
Impact of Domestic Violence on CYP	Sept 14, Nov 14, March 15	72	100% exceeded or met expectations
IOWSCB Annual Conference	9th Sept 2014	155	87% extremely good or very good
Learning Lessons	Oct 14	243	98% strongly agree or agree met stated outcomes
Neglect Conference	6th June 2014	119	n/a
Parental Mental Health & Safeguarding	Nov, Dec 14	119	99% strongly agree or agree course met stated outcomes
Sandstories	June, July, Oct, Dec 14	175	100% met stated learning outcomes
Rapid Response	March 2015	12	n/a
4LSCB Protocol Launch	10 July 2014	120	n/a

How the Board has worked in practice during 2014-15 to ensure that children are safeguarded on the Isle of Wight

Impact of Multi-Agency Training

In partnership with the Hampshire LSCB Workforce Development Group a method of testing and evidencing the impact of multi-agency training was trialled in 2014 with the Sandstories training courses that were held between July and December. This is an area for improvement identified in the Ofsted report published in November 2014. The evaluation used comparative pre and post course data from participants, and feedback from managers three months after the training. This pilot has been successful both in achieving evidence of the impact of training, and in engaging managers directly in thinking what should have changed as a result of staff attending training. The Board will develop this work in the future.

Quotes from Attendees at the Sandstories Training:

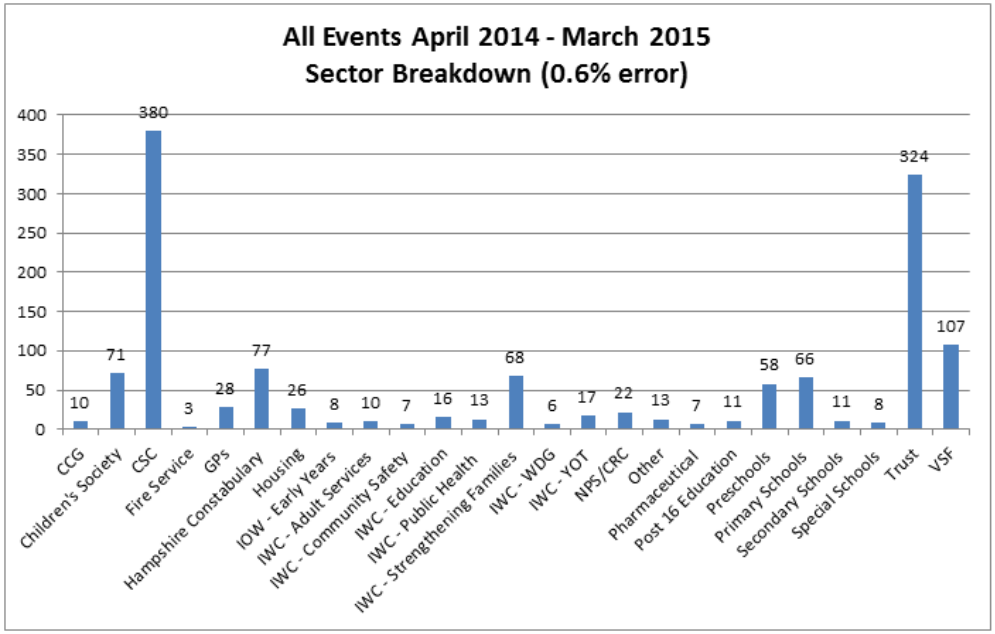
"I understand the impact of fear and stress on infant resilience and survival"

"Fantastic Workshop, very effective way of showing the focus of the child on visits"

'..I hear the phrase ' but what does it look like for the child' much more frequently when having supervision and team meetings'

The Sandstories training proved so popular that further dates were booked to meet demand. In 2014-15 we were able to offer a range of quality training courses, and these were well attended by practitioners.
We make a charge for non-attendance, and this has ensured that people prioritise the courses that they have booked.

In order to ensure that our training courses are meeting the needs of a wide range of practitioners, we monitor which sectors attendees are from.



How the Board has worked in practice during 2014-15 to ensure that children are safeguarded on the Isle of Wight

Challenging and Supporting Agencies to Work Together Effectively to Safeguard Children on the Island

The Board has worked to develop the scrutiny role of the Performance and Quality Assurance Sub Group. The group carries out this function in a number of ways:

IOWSCB Thematic Audits

The IOWSCB undertook four Thematic Audits this year, and received a report from the Child Protection Audit that was undertaken in March 2014. Audits have comprised three elements: multi-agency case reviews which directly involve practitioners; electronic staff surveys; and meetings with children and their carers. The purpose of the audits is to assist the IOWSCB to identify where practice could be improved through, for example, access to additional training or developing protocols. Audit outcomes are used by the IOWSCB to challenge individual agencies and improve multi-agency working.

Child Protection Audit

There were some lessons learnt about process through this audit, including case selection and access to case recording. The audit led to an immediate review of contingency plans for several of the cases. Issues were raised in relation to: circulation of child protection conference and core group minutes; management oversight; and transfer of information to new schools. These issues have been addressed. The issue of disguised compliance was raised, and has been addressed extensively through the Board's training programme during the year.

Section 47 (Children at risk of "significant harm") Audit

8 cases were audited. 1 was outstanding, 3 were good, 3 required improvement and 1 was inadequate. There were some elements of outstanding practice. Areas for improvement included: weaknesses in relation to the use of domestic abuse risk assessments; maintaining appropriate responses to families who move on and off the Island; and the need for greater involvement of adult and housing services in child protection cases. In addition there were some concerns about multi-agency work, including different perspectives taken by agencies in relation to neglect. Parent and child feedback indicated a need for improved communication and involvement in the process. The findings of the audit were broadly reflected in the subsequent Ofsted inspection. Actions have been taken in response to all of the issues identified.

Neglect Audit

The numbers of children on a statutory plan under the category of neglect has continued to increase on the Island. The outcomes of the audit were positive. 11 cases were examined, spanning the journey of the child from early help to looked after children. The cases evidenced some good practice across all areas. No inadequate areas were identified. The cases which required improvement were in relation to the timeliness of seeing the family, communication with the referrer and use of the agreed step down process. The responses from parents were generally positive, particularly in relation to communication and intervention. Practitioners indicated a high level of awareness about neglect, and identified training needs which will be included in the Board's needs analysis. This audit has also resulted in the initiation of a multi-agency strategy on neglect which will aim to improve professional responses and consider the development of additional resources to support practitioners.

Parent-Carer feedback from the Neglect Audit was that one of the main issues that all parents and carers positively reported on was the practical support they received. This ranged from application forms and budgeting to healthy eating and domestic maintenance signposting. One carer felt that this made the difference between coping in the situation and not being able to continue as a foster carer.

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

MASH Audit

The purpose of the audit was to test the threshold decisions made by MASH with regards to referrals, and Section 47 investigations. Overall the audit showed a robust use of thresholds by MASH, and appropriate sharing of information with other agencies. Of the 15 cases audited in relation to Section 47, 14 cases were good and 1 was outstanding. The audit highlights the need for MASH to have access to the IOW electronic recording system so they can view previous records. The issue of multi-agency meetings for unborn babies also needs reviewing. These recommendations will be followed up through the subgroup's multi-agency audit action plan.

SECTION 11 AND SECTION 175/157 AUDITS

Section 11 of the Children Act 2004 places duties on a range of organisations to ensure safe systems and processes are in place e.g. safe recruitment of staff, appropriate training and up to date policies which all staff know how to access.

Working Together to Safeguard Children (2015) requires LSCBs to gather information to assess whether partners are fulfilling their statutory obligations under section 11. On the Island, the IOWSCB monitors compliance by requiring agencies to use a self-assessment tool to review their practice for compliance. Once the tool is completed, an action plan is made and the tool is sent back to the IOWSCB for scrutiny. A section 11 audit took place across Island agencies in 2013/14 and is due to take place again in the coming year. The outcome was generally positive; each organisation made an action plan and the IOWSCB undertook checks on progress and actions required.

Section 175 and Section 157 of the Education Act 2002 identifies a similar safeguarding audit process for schools (Section 157 applies to independent schools). The IOWSCB sent the Section 175/157 audit tool all schools in November 2014. 100% schools returned their audit tools and audit visits to verify the evidence took place in June 2015. A report on the audit tool and audit visits will go to the Board in autumn 2015.

A Section 11 safeguarding audit was sent out to all 52 childcare providers on the Island in the summer term 2014. Childminders were not included in this process. There was a 98% return. The self-assessments were generally positive in relation to safeguarding policy and practice. Work was undertaken to follow up on issues arising, including the sector's understanding and use of the CAF process.

DATA

All agencies are providing data on a quarterly basis to the Performance and Quality Assurance Subgroup so that patterns and trends can be analysed and appropriate action taken when needed to safeguard children on the Isle of Wight. There are still some difficulties in getting Police, Community Rehabilitation Company (CRC) and Education data and we will continue to focus on these in 2015-16.

SINGLE AGENCY AUDITS

Individual agencies carry out internal audits and report back to the Performance and Quality Assurance Subgroup so that learning is shared.

CIN STRATEGY

A CIN strategy was ratified in May 2014 by the Board following the CIN Audit that took place in February 2014. Practitioners are now much clearer about Child in Need status and the creation of an additional Child in Need team has greatly increased capacity within Children's Social Care. The Children in Need provision was re-audited prior to the publication of this report with improvements seen.

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

Engagement with and Participation of Children, Young People and Families

Across the Children's Trust there is a strong platform for participation work with both children and their families. Examples of this work, and the forums that support participation, include: Children in Care Council which meets monthly; Have your Say Day; the Youth Council; and Star awards which celebrate children's achievements. In addition children are involved in the Corporate Parenting Panel, and there is a Young Inspectors team of disabled children who attend short break provider activities and rate them using a standard format. Increasing use is being made of the internet and social media by both the Board itself and its partners to enable better communication with children and their families. For example the Clinical Commissioning Group's 'Check it Out' website and the 'Check it Out' group for young people aged 11-19 years, both of which 'invite comment on health services' through 'mystery shopping' feedback and discussion'.

The view of Ofsted in 2014 was that the IOWSCB needed to strengthen the engagement of young people in its own work so children's experience informs development and is included in the evaluation of safeguarding on the Island. The Board is committed to implementing this.

The Board has two places for lay members, one of which is designated for a young person. This place has remained vacant during the year despite recruitment activity and the Board seeks to fill this during 2015-16.

Conferences and training events during the year have involved children directly, or have enabled the Voice of Children to be strongly heard. The Early Help Anti-Bullying conference in October 2014 was supported by the IOWSCB and involved many school children in workshops and a poetry competition.

"It's good to feel listened to and that I can make a difference"

"When I deliver the training it helps me to think about how I come across to people"

The SCR Learning Lessons events adopted a fresh format, using materials and case studies written from the child's perspective.

Feedback from some of the 243 Learning Lessons participants:

"I will make sure records are accurate and complete and if things need to be taken further, I will keep going until it is followed up"

"I will keep other professionals updated via email on the case"

"small pieces of information we have need to be shared because they may be relevant to the bigger picture"

"professional curiosity is important"

All IOWSCB Audits this year have included the voice of children and their carers. The Children's Rights and Participation Officer met with families to hear what they have to say about issues such as communication, support received and their understanding about statutory processes. There were positive messages for services from this work, particularly through the Neglect Audit, as well as concerns and suggestions for improvement. The outcomes from this participation work informs the conclusions of the audits, and has directly prompted the development of a guide for young people and families about statutory processes in social care, and training for staff about how to communicate with young people.

"Most workers want to do a good job, but some forget that young people want to be involved as much as possible"

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

Involving Practitioners and Managers

The experience of frontline staff and their managers is integral to improving safeguarding practice and procedure on the Island. The views of staff impact on all areas of the work of the Board and are directly included in Audits, Serious Case Reviews and event feedback.

An additional method used by the IOWSCB to obtain feedback from front line staff is 'Board Walkabouts'. These were undertaken between May and July 2014. IOWSCB members visited 12 settings across the island including:

- **Probation Service**
- **GPs - Sandown Health Centre**
- **Community Children and Adolescent Mental Health (CCAMHS)**
- **Ambulance Hub**
- **Police (MAPPA)**
- **Maternity Unit**
- **Community Midwives Clinic (Ryde Sure Start)**
- **2 Pre Schools (Ryde Pre School and Bembridge Children's House Montessori)**
- **Children's Centre (The Bays)**
- **MASH/CRT**
- **Youth Offending Team**

Staff feedback from the Walkabouts was reported to the Board in September 2014 and the Performance and Quality Assurance Subgroup have used this information. Requests for training expressed by staff in their feedback have informed the training needs analysis for the year. Positive indications included a high level of understanding about the role of the Board, appreciation from staff of the policy and procedures that are now in place, and reports that the MASH was working well.

Staff requested more information on the processes around child deaths and made some specific request for further training such as chronology writing. Rapid Response training has been put in place and the request for chronology writing has gone to the Workforce Development Subgroup. With regards to multi-agency working, staff reflected on some improvements. An area highlighted as needing improvement was communication and discharge planning between maternity services and children's social care.

In October a Practitioner Forum was established so that practitioners had a mechanism for on-going communication with the Board. There was a very low uptake when this was trialled and so this forum function has now developed through the Public Health Outreach Group as a joint forum for practitioners to encourage their attendance and participation.

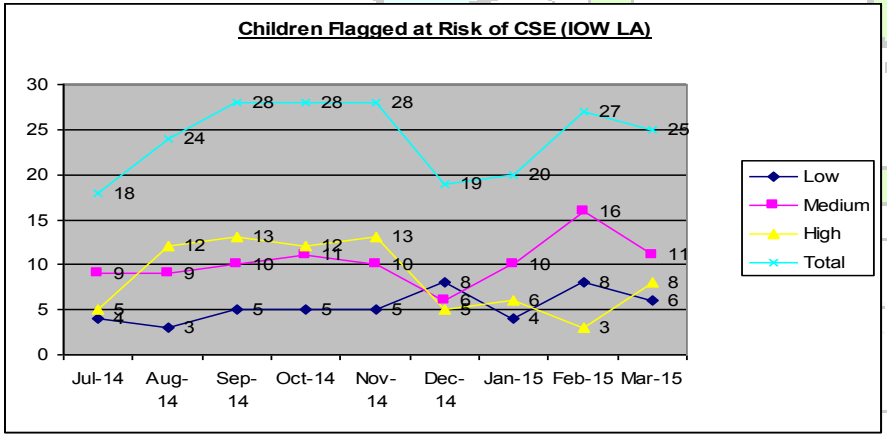
How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

Missing, Exploited and Trafficked Assessment

There has been a huge amount of investigation, review and learning in relation to child sexual exploitation nationally during 2014-15. The Board has been cognisant of this throughout the year, and there have been welcome developments within multi-agency work on the Island and within the 4LSCB area.

1. Revision of the 4LSCB MET Terms of Reference

2. Problem Profile - this work led by Hampshire Constabulary establishes that the demographic for children identified as highest risk is presently white females aged between 14 and 17, the majority of whom live with their families. The Isle of Wight presently has the second highest number of 'at risk' cases identified across the 4LSCB area. Intervention and prevention work has recently shown a decrease in the numbers of high risk cases at METRAC. The number of children at high risk has ranged from 5 in July 2014 to 8 in March 2015, with a peak of 13 in November 2014. See the table below for a fuller picture:



3. Sexual Exploitation Risk Assessment Framework (SERAF) is used by practitioners and monitored through the METRAC group to enable consistent use of thresholds. The Island does not have an identified 'crime ring' for CSE. The majority of cases identified are 'peer on peer' with older peers within groups posing the threat. This intelligence enables sound action plans to be established for those at risk.

4. Early Help provision now provides streamlined support to parents as well as preventative work with children at risk or impacted by CSE.

5. Position statement in relation to compliance with the recommendations arising from the enquiry into CSE in Rotherham: all Board partners have responded to this. Partners are concerned that there is a lack of therapeutic aftercare provision for the victims of CSE and this will need to be a future consideration. The Problem Profile is being developed further with more information on the perpetrators of CSE and this needs to be urgently completed in 2015.

6. Hampshire Constabulary continues to investigate non recent allegations of CSE. It was reported that historic allegations have been recorded and investigated appropriately. The Police have also commissioned specialist CSE teams to work more pro-actively - for example identifying sexualised behaviours. Work to develop the MET group functions will need to continue in 2015 as a priority area so that it has a positive impact on reducing CSE on the Isle of Wight.

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

7. Further funding was obtained from the Office of the Police and Crime Commissioner for an extended roll out of "Chelsea's Choice" by the theatre company 'Alter Ego'. This is an innovative play for young people which is followed by a plenary discussion. The performance describes the journey of a young woman into an exploitative relationship and has proven highly effective in:
   - Raising Awareness of Healthy Relationships
   - Promoting Safe Internet Use
   - Identifying Risky Situations
   - Raising Awareness of The Grooming Process & the differing forms that it can take
   - Raising Awareness of Child Sexual Exploitation & the differing forms that it can take

Feedback from students attending Chelsea's Choice, February 2015: What will you most remember from today?

"Always bring a friend if you are meeting someone from the internet"

"How he manipulates her so much"

"How there is always a way out"

8. IOWSCB Annual Conference: "Adolescents at Risk" - The Board's annual conference took place in September, and the focus was on Adolescents at Risk. This event was attended by 155 delegates. Chelsea's Choice was shown to the conference delegates and was well received.

Feedback from IOWSCB Annual conference delegates:

"Alter Ego were amazing"

"Inspiring speakers and drama"

9. National CSE Awareness Day was in March 2015 and the Participation Officer and staff took a bus to the Isle of Wight College to survey a student group to gain their views and knowledge of CSE. The event was called 'Helping Hands' and children wrote statements on their hands to raise awareness as below. These images were tweeted on @IOWSCB using #HelpingHands.

How the Board has worked in practice during 2014-15 to ensure that Children are Safeguarded on the Isle of Wight

Allegations Against Professionals

The Local Authority Designated Officer (LADO) should be informed of all allegations against adults working with children, and provides advice and guidance to ensure individual cases are resolved as quickly as possible. There has been a 10% decrease in referrals, a total of 155, to the LADO service during the period of April 2014- March 2015 compared to the previous year when there were 170. Most referrals come from within the schools setting which is unsurprising as school based staff make up a large proportion of the children's workforce and tend to have the most face-to-face contact with children.

The LADO works closely with pre-school and education settings, as well as more widely across children's services and the voluntary sector supporting designated safeguarding officers to respond to allegations appropriately, including responding to new regulations such as the disqualification "by association" regulations which came into force this year.

Referrals (2014-15) by Category and Workplace

	Physical	Emotional	Sexual	Neglect	Conduct	Total
School	22	2	10	2	8	44
Children's Services*	1	1	1	-	5	8
Foster Carers	4	1	3	3	2	13
Nurseries/ Pre-Schools	2	-	-	-	1	3
Health	-	-	-	1	1	2
Leisure	-	-	2	-	2	4
Private/Voluntary Sector	1	2	7	-	2	12
Religion	-	-	2	-	1	3
Other	-	-	1	-	-	2
Total	31	6	26	6	22	91

*Children's Services includes any member of the Isle of Wight Council staff whose line management structure comes under the Strategic Partnership arrangements between the Isle of Wight Council and Hampshire County Council.

Recruitment and Workload

During the reporting year 2014-15, there were some key pressures on recruitment and retention of staff. In particular the Board was concerned about pressures on the health visiting and school health nurse service which impacted on workloads. Healthwatch Isle of Wight reported concerns about pressures on antenatal services. Health commissioners reported to the Board that they are looking to review the Early Help Offer (0-19) and to build on the "Family Platform" in the Wessex region which will enable individual health professionals to transfer skills and work more flexibly across health roles. The Board will keep this issue under review.

In 2014-15 there were workload pressure in some teams in Children's Social Care particularly Child in Need and Looked After Children. Children's Social Care created additional resource and the situation is now stable. Concerns about the number of agency staff have also been addressed during the year, and this is reducing although there are a significant number of newly qualified Social Workers.

Recruitment within the Youth Offending Team was successful in 2014-15.

How the Board responds to Child Deaths on the Isle of Wight

Child Deaths on the Isle of Wight

Every child's death is a tragedy. When a child dies, the Child Death Overview Panel (CDOP) carries out a systematic review to help understand why the death has occurred. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and to prevent future deaths. The CDOP enables the IOWSCB to carry out its statutory functions relating to child deaths.

The four Local Safeguarding Children Boards in Hampshire, the Isle of Wight, Portsmouth and Southampton currently have a joint Child Death Overview Panel, although these arrangements will change in November 2015. CDOP has representatives from Public Health, Designated Nurse for Safeguarding, Paediatrics, Hampshire Constabulary, Education and Social Care, South Central Ambulance Service and Midwifery Services.

The CDOP process has two integral parts:

A "rapid response" process which takes place when a child dies unexpectedly. Overseen by CDOP, a group of professionals work together to review the circumstances, and to inform understanding about the reasons for the child's death.

An overview of all child deaths in the 4LSCB area, undertaken by the Panel which meets bi monthly to identify any issues of concern affecting the safety and welfare of children in its area. The Panel also considers any wider public health or safety concern.

In 2014-15 there were 6 child deaths on the Isle of Wight of which 2 were unexpected.

From November 2015 the IOWSCB will have a separate CDOP that will report to the Board as part of a joint CDOP and Serious Case Review Subgroup. The Rapid Response Procedure has been reviewed and a policy is in place. Training on the Rapid Response Process is being made available to all staff through the IOWSCB Training Programme in 2015.

How the Board Has worked to Review Serious Cases and Advise on the Lessons to be Learned

Serious Case Reviews

Regulation 5(1)(e) and (2) of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs to undertake reviews of serious cases in specified circumstances, and to advise the authority and its partners on the lessons to be learned. A serious case is one where:

> **(a)** Abuse or neglect of a child is known or suspected; and
>
> **(b)** Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child

LSCBs must undertake an independent review of all these cases. These reviews are called Serious Case Reviews (SCRs). The purpose of a SCR is to identify any lessons to be learnt from the case about multi-agency safeguarding practice. SCRs also identify instances of good practice and consider how these can be shared and embedded. The IOWSCB acts to ensure that lessons learned from reviews are used positively to inform practice improvement, and it works through its designated Serious Case Review Subgroup and Workforce Development Subgroup to achieve this.

The statutory guidance, Working Together to Safeguard Children 2015, advises that if the criteria in regulation 5(2) are not met, the LSCB may still decide to commission a SCR or an alternative form of review. The IOWSCB has undertaken Partnership Reviews where the case does not meet the criteria, but it is considered that there are lessons for multi-agency working to be learnt.

At times there have been difficulties in defining serious harm as described in legislation. Two Serious Case Reviews were published during the year, Family Q and Baby Z. Two further Serious Case Reviews were commissioned during the year, Child D and Child E.

IOWSCB Commissioning, Approval and Publication of SCRs during 2014-15

Case	Date Commissioned	Final Report	Date of Publication
Q Family	October 2013	July 2014	March 2015
Baby Z	January 2014	July 2014	October 2014
Child D	March 2015	-	-
Child E	March 2015	-	-

In 2014, the Board commissioned a thematic summary of recommendations from the 15 Serious Case and Partnership Reviews that have been undertaken since 2007. The purpose of this analysis was to review the recommendations from these reviews and to establish a combined action plan. Agencies are accountable to the Board in relation to achieving these, and the outstanding actions resulting from this review will be scrutinised by the IOWSCB during 2015-16.

How the Board Has worked to Review Serious Cases and Advise on the Lessons to be Learned

The two stories that follow were used in Lessons Learned sessions with practitioners. The cases were anonymised and adapted to protect the families.

Jaz's Story (Family Q)

Jaz had several siblings and the family was characterised by continuous problems which involved professional agencies. The children experienced a chaotic upbringing where heavy handedness and sorting problems through violence was seen to be the norm. The children witnessed many incidents of domestic violence and other disputes, and many Police interventions. The disputes continued even after the parents had split up and had new partners. The atmosphere of conflict and physicality was such that some of the children themselves became violent between themselves, and with others outside and inside the family.

There were concerns about the quality of parenting when the children were young, frequent A&E attendance including injuries when young, and concerns about their failure to thrive.

Over a period of nearly two decades, professionals found dealing with the family very hard, mainly because of the volatile, aggressive and manipulative nature of the father, and because of the turbulent relationship between the adults.

Over many years there were allegations that one or more or the children were at the very least subject to a highly sexualised environment, or sexually abused or at risk of such abuse, either through parentally uncontrolled access to a high risk individual, or by a family member. Such suggestions of sexual abuse were investigated on a number occasions over a decade by the Police and/or Children's Social Care but with 'no further action' conclusions. There was eventually a conviction in relation to a number of offences against Jaz.

Lessons learnt/areas for improvement:

- Time to step back and reflect in complex, long term cases
- The impact of aggressive parents should be understood and staff supported to become resilient
- Assessments should take the full history into account
- Address optimism in the face of changing evidence through good supervision and case review
- Giving and receiving challenge should be valued and modelled
- Escalation procedures to resolve inter-professional disputes should be understood and used
- Understand that the resolution of a current problem does not prevent the consideration of the long term wellbeing of children
- Processes should be in place for multiagency discussion of chronic cases
- Staff should have time to discuss their views at conferences without parents being present
- Children's Social Care should convene multi-agency meetings to discuss major concerns raised by other agencies
- Contradictory evidence from children about an allegation or disclosure:
  - Should not lead to failure to consider what is happening overall, and
  - Should be considered as a possible indicator of abuse rather than something which disproves it

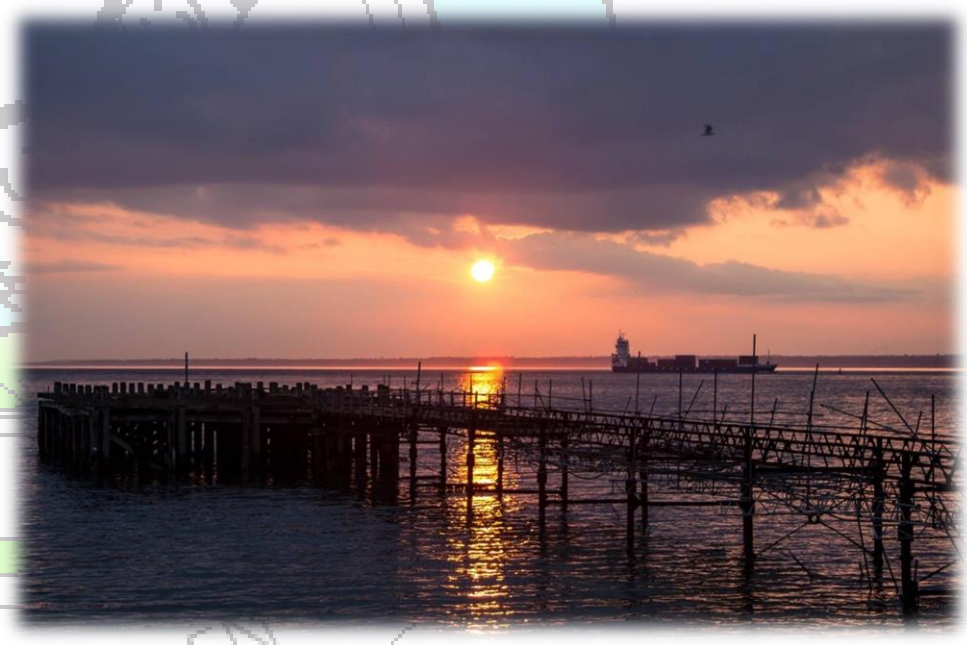
How the Board Has worked to Review Serious Cases and Advise on the Lessons to be Learned

Zac's Story (Baby Z)

Zac was a very young baby who died at home. The cause of death was unascertained but it is known that no aspect of safe sleeping advice given to the parents was implemented. Of particular significance was that Zac had fallen asleep on the sofa with his father, who had used both alcohol and drugs that evening. Zac's mother had been known to mental health and substance misuse professionals prior to the birth and his father had a history of drug related offences.

Lessons learnt/areas for improvement:

- Improved use of early help (CAF) assessments
- Use of vulnerable mother referral in mental health services (See 'Joint Working Protocol' at iowscb.org.uk)
- Development of consistent system for passing medical and social history between midwives and GPs
- Consistent information sharing between agencies about the father of unborn babies
- Formal information sharing across midwifery when a mother moves area
- Written notifications when case closed due to disengagement
- Improved use of coding within GP records
- Increased awareness of the impact of drug use on babies pre and post birth
- Use in practice of current knowledge about mental health, drug use and domestic violence and effect on parenting capacity
- Access to adult social care information in the multi-agency safeguarding hub (MASH)



Summary of Sufficiency of Arrangements

Effectiveness, Contribution and Challenge

Maggie Blyth, Independent Chair said:

"Our strategic priorities will focus on safeguarding the most vulnerable children on the Isle of Wight because we know they are the least safe and achieve the worst outcomes.
To do this successfully we will need to focus on ensuring that child protection arrangements are right over the next year. This will mean putting in place strong governance arrangements, being clear about our collective roles and responsibilities and implementing a rigorous and effective quality assurance framework."

The Board has three overarching Priorities for its 2013-2016 Plan, which are refreshed annually. See the Key Priorities below.

Key Priorities	Progress Made
1. Leadership and Governance *To have in place transparent and effective partnership governance structure that confirms and evidences clear leadership of safeguarding across the Island. All meetings enable an open, effective dialogue to take place so that the Board routinely monitors, challenges practice and identifies barriers to improvement*	• Attendance at Board and Subgroup meetings continues to be monitored. There is a need to increase attendance by Probation in the coming year, as well as better attendance by Education though this is usually connected to meetings held outside of term time. Health now attend a full range of meetings. • Work to involve children in the work of the board needs further development. • The Subgroups meet regularly and report back to the full Board meetings quarterly. • Subgroups monitor and review their work plans but this needs further attention in the coming year to ensure there is no slippage and that progress is made in all areas of the Business Plan.
2. Scrutiny, Performance and Assurance *The Board evaluates the effectiveness of the safeguarding system and is fully aware of the performance on safeguarding children through the consistent use of information to drive the quality of service and delivery of outcomes vigilantly, transparently and unfailingly across all agencies.*	• A challenge log is in place to record challenges and responses to them. This ensures that issues are escalated when not resolved. • Agencies are producing quarterly data reports to the Performance and Quality Assurance Subgroup. There have been difficulties with Probation, Police and Education reports and these seem mainly to be due to capacity issues. In the coming year these issues will need to be addressed. The reports have been amended to ensure that agencies provide a narrative to accompany the data showing analysis of patterns and trends and what actions are being taken where there are issues. • Annual reports are presented to the Performance and Quality Assurance Subgroup from a range of areas. These are being used to inform training needs, and business planning. • The Annual Report will be presented to a variety of groups including the Isle of Wight Council, Police and Crime Commissioner, and the Health and Wellbeing Board.

Summary of Sufficiency of Arrangements

3. Improving the Quality of Practice *Practice improvement is supported through a consistent Board wide learning and improvement framework, effective support and supervision arrangements, providing the right training for the right practitioners and the learning from every type of review and audit is proactively disseminated and acted upon*	• 4LSCB online procedures are reviewed by the 4LSCB procedures group and practitioners are using these together with the website, Twitter and newsletter to keep themselves up to date. • The Workforce Development Subgroup carried out an Annual review of training using a needs analysis tool as well as information from Subgroups, Deep Dive Audits and SCR Report findings. Training was then planned for the 2014-15 year. • The 4LSCB CDOP Annual Report was presented to the Board. • The Thresholds document was drafted and practitioners were consulted via the Performance and Quality Assurance Subgroup before it was finalised and launched. • A multi-agency event was held in July 2014 to launch some IOWSCB protocols. • The Annual Conference in September 2014 was really well received and has made practitioners more aware of the work of the IOWSCB. • There is a co-ordinated response to CSE. The METRAC group have worked really hard to assess risks and ensure children receive appropriate support. The MET group need to plan more strategically and ensure that this Subgroup has a real impact on awareness raising and reducing the number of children at risk of CSE, missing or trafficked.

Summary of Sufficiency of Arrangements

Impact of and Response to Inspection

Overview Assessment of Progress since OFSTED

In September 2014 an Ofsted inspection was undertaken into the effectiveness of the IOWSCB, alongside an inspection of children in need of help and protection, children looked after and care leavers. Ofsted's Inspection Report was published in November 2014. The overall judgement was that the Board and the services inspected required improvement. The inspectors acknowledged the progress made in strengthening the partnership and holding partners to account. The effectiveness of the Subgroups in driving the delivery of the strategic plan was highlighted. However, Ofsted stated the priorities were focused on 'establishing basic foundations' and did not sufficiently address the broader issues of mental health, substance misuse, domestic abuse or neglect.

Areas for improvement	Actions Taken
Quality Assurance, Data and Performance	
Evaluate the quality of multi-agency partnership work with children at risk of significant harm on a continuing basis and use the learning to drive improvement	The IOWSCB has undertaken a number of Deep Dive Audits during the year and acted upon the recommendations. Recommendations from Serious Case Reviews and Partnership Reviews are disseminated through Learning Lessons sessions for practitioners and discussed at Board meetings which inform the Business Plan.
Develop an understanding of local need from data, particularly in respect of adult metal health, substance misuse, domestic abuse and neglect. Use this to determine IOWSCB priorities and to scrutinise the work of other strategic partnerships	The IOWSCB is planning to revisit the Toxic Trio at its Annual Conference in October 2015 and to develop a Neglect Strategy.
Consolidate the existing use of multi-agency data to analyse trends and performance and to identify key areas for improvement.	The Performance and Quality Assurance Subgroup have further developed Quarterly Data Reports to include analysis of data and actions needed and this will need further consolidation in the coming year.
Ensure that the IOWSCB gains a clear understanding of the reasons why children go missing to identify trends and patterns and improve service response to those who go missing, including those young people at risk of child sexual exploitation.	The METRAC Group is very proactive in identifying and meeting the needs of Children at Risk of Sexual Exploitation and the Education Welfare Officers have robust systems for tracing children who go missing.
Strengthen the engagement of and consultation of young people in the Board's work so that children's experience can inform developments and be included in the evaluation of improvement.	There have been some positive examples of participation of children during the year. This work needs to continue in the coming year.

Summary of Sufficiency of Arrangements

Governance	
Develop robust links with the Family Justice Board to scrutinise the safeguarding of children in public and private law proceedings.	The Chair and Board Manager met with Family Justice Board members to develop partnership working and a memorandum of understanding for partnership working has been completed.
Strengthen the IOWSCB's scrutiny of public protection arrangements on the Isle of Wight, particularly in respect to the MAPPA and MARAC	MAPPA submitted their first annual report to the Performance Quality and Assurance Subgroup in 2014. The Hampshire and Isle of Wight MAPPA is led by a Detective Chief Inspector. This ensures a high level of consistency in management across the force. Work is ongoing with the local Criminal Justice Board and Strategic Management group to examine how the Integrated Offender Management Team (IOM) and MAPPA Schemes interact to ensure they work closely together. Training to raise awareness of Sexual Abuse and Child Sexual Exploitation have been planned and will be rolled out over 2015/16
Development of Key Areas	
Raise awareness of privately fostered children on the Isle of Wight among agencies and the community.	Information has been sent to agencies and the local community about Private Fostering. There is just one child currently recorded as being Privately Fostered which we know is not a true picture. The IOWSCB will be targeting schools who have the most contact with children likely to be Privately Fostered to ensure increased knowledge and understanding of this issue.
Deliver a multi-agency training programme based on the outcome of the training needs analysis and develop mechanisms to evaluate the impact of training on practice.	The IOWSCB has a multi-agency training programme in place resulting from the Training Needs Analysis carried out by the workforce Development Subgroup. A pilot analysis was completed for the Sandstories training and this showed a positive impact on practitioner knowledge and confidence.
Strengthen the work of the voluntary sector and the faith sector and ensure that the partnership has clear advice and guidance around safer recruitment.	Safer Recruitment Training was delivered for the voluntary sector, and this will need to remain a priority to ensure that this sector is provided with the knowledge and understanding needed for safe practice.
Develop work regarding e-safety and ensure that principles of safe practice and guidance for children and their parents are used across the partnership and community.	PC Finch delivered e-safety training to 17 carers and young people. The feedback was positive and further training for parents/carers has been planned and this will be delivered in autumn 2015.
Review the effectiveness of the Child Death Overview Panel (CDOP) in identifying modifiable cases of child death and implementing learning	After review, it was agreed to separate the 4LSCB CDOP so that each LSCB area has its own child Death Overview Panel. Discussions about how this transition will be made have taken place and the move to an Isle of Wight CDOP will be implemented later in 2015.

Challenges and Future Priorities

Challenges and Implications for Future Priorities and Planning

The Board has made substantial progress in strengthening partnerships and holding partners to account. The IOWSCB now needs to move its focus from establishing basic foundations to addressing issues that are affecting the wellbeing and safety of children on the island.

Taking account of outcomes from audits, learning from reviews and analysis of performance it was agreed that the focus for 2015-16 for the Isle of Wight Safeguarding Children's Board would be:

- The Toxic Trio of Parental Mental Health, Domestic Abuse and Parental Substance Misuse
- Neglect
- Early Help
- Child and Adolescent Mental Health

The Board will work to deliver actions to better understand the impact of these issues on the lives of children and families and introduce improvements to frontline practice so that the services offered achieve the best possible outcomes for children.

Nationally, the following areas continue to have a high profile:

- Tackling Child Exploitation
- Improving the Effectiveness of Early Help Services
- Implementing new Statutory Safeguarding Guidance, including Inspection Frameworks
- Ensure that potential risks to safeguarding practice and arrangements are kept under review in a climate of increasing demand and reshaping of public services

The IOWSCB has membership from a wide range of professionals. The purpose of the Board will be to set the strategic priorities and engage organisation leaders in evidencing improved outcomes for children. The Subgroups will be responsible for the operational delivery of specific elements of the Business Plan ensuring engagement of practitioners and hearing the Voice of the Child. Task and Finish Groups will be set up to deliver specific time limited priorities. A new small executive group will drive delivery of the Business Plan. There is a need to recruit two lay members to the board and this will be a priority in 2015.

Challenges and Future Priorities

Key Messages to Groups

Local Politicians
They can be the eyes and ears of vulnerable children and families in their ward, making sure their voices are heard by the IOWSCB. Councillor Jonathan Bacon is the Lead Member for Children and Families and provides the route for individual Councillors to make sure the voices of children are heard, and for Councillors to be aware of local safeguarding priorities for children.

Clinical Commissioning Group (CCG)
The Clinical Commissioning Group in the Health Service have a key role in scrutinising governance and planning across a range of organisations ensuring that services are effectively commissioned for the most vulnerable children.

Police and Crime Commissioner (PCC)
The PCC ensures that the voices of all child victims are heard within the criminal justice system, particularly where children disclose abuse. They should continue to monitor what police and probation staff do to share information regarding high risk MAPPA and MARAC cases, and the risks some adults present to children.

Chief Executives and Directors
They ensure their workforce is able to both contribute to the provision of IOWSCB safeguarding training and attend courses and learning events. They ensure their agency gives IOWSCB work the highest priority. This includes meeting the duties of Section 11 of the Children Act 2004 and that they are able to contribute to the IOWSCB work programme appropriately.

Head Teachers and Governors of Schools
They ensure that their schools are compliant with 'Keeping Children Safe in Education' (DfE 2015) which all schools must follow to safeguard their children.

Children's Workforce
They ensure staff attend all safeguarding courses and learning events required for their role, become familiar with the IOWSCB website and use when necessary the thresholds and procedures documents to ensure that they respond appropriately to safeguarding children. They participate fully in IOWSCB Deep Dive Audits ensuring the voices of children and frontline practitioners are heard.

Community Members
They are in the best place to look out for children and to raise the alarm if something is going wrong. If someone is worried about a child, they should call the Children's Reception Team on 0300 300 0117.

Local Media
They are ideally positioned to communicate the message that safeguarding is everyone's responsibility and that this is crucial to the IOWSCB.

Children
Children's voices are the most important of all. The Board plans to develop better ways of listening to their voices and explaining things to them.

Appendix A

Isle of Wight Safeguarding Children's Board Members 2014-15

Partner Agency	Representative
IOW Council Lead Member	Councillor Jonathan Bacon
Detective Superintendent, Hampshire Constabulary	Det Supt Rachel Bacon
Chief Executive, Isle of Wight NHS Trust	Karen Baker
Offender Management Director, Hampshire Probation Trust	Sarah Beattie
Independent Chair, IOWSCB	Maggie Blyth
Board Manager, IOWSCB	Julie Davies
Chair of Serious Case Review Subgroup (Independent Consultant)	Carol Douch
Head of Commissioning, Community Wellbeing and Social Care, IOW Council	Mark Howell
District Service Manager, Education and Inclusion, IOW Council	Steve Cottrell
Director of Children's Services, Hampshire and IOW Council	John Coughlan OBE
Deputy Director for Children's Safeguarding, Hampshire and IOW Council	Steve Crocker
Associate Director of Public Health, IOW Council	Dr Rida Elkheir
Safeguarding Adults Board and Domestic Abuse Co-Ordinator, IOW Council	Fleur Gardiner
Area Director of Children's Services, IOW Council	Steve Handforth
CAFCASS	Gillian Heath
Associate Director, IOW NHS Trust	Gill Kennett
Detective Superintendent, Hampshire Constabulary	Det Supt Nigel LeCointe
Primary Heads Forum	Maxine Leppard
Designated Doctor, Isle of Wight NHS Clinical Commissioning Group	Dr Christopher Magier
Principal Lawyer, Legal Services, IOW Council	Janet Paine
Assistant Director of Nursing, Wessex Area Team, NHS England	Nicky Priest
Detective Inspector, Hampshire Constabulary	DI William Reid
4LSCB CDOP Manager	Jill Sephton
Executive Director of Nursing & Lead for Safeguarding, IOW NHS Trust	Alan Sheward
IOW Clinical Commissioning Group	Helen Shields
Operations Manager, Hampshire and Isle of Wight Youth Offending Service	Alison Smailes
Designated Nurse, Isle of Wight NHS Clinical Commissioning Group	Dr Lorraine Smith
Named GP, NHS England	Dr Dawn White

Glossary of Terms

CAF - Common Assessment Framework

CCG - Clinical Commissioning Group

CDOP - Child Death Overview Panel

CIC - Children in Care

CIN - Child in Need

CP - Child Protection

CQC - Care Quality Commission

CRT - Children's Reception Team

CSE - Child Sexual Exploitation

IOWSCB - Isle of Wight Safeguarding Children Board

LAC- Looked After Children

MAPPA - Multi-Agency Public Protection Arrangements

MARAC - Multi-Agency Risk Assessment Conference

MET - Missing, Exploited and Trafficked

PQA - Performance and Quality Assurance

SCR - Serious Case Review

TAF - Team Around the Family

WFD - Workforce Development

YOT - Youth Offending Trust

Publication

Authorship	*Jane Leigh, Debbie Pledge and Emily Galt of the Isle of Wight Safeguarding Children's Board Business Unit*
Date of Approval by The Board	*Draft approved by Board 30th July 2015*
Date of Publication on IOWCSB Website	*6th October 2015*
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Safeguarding Children - The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances