Hillingdon Local Safeguarding Children Board Annual report 2010-11

'That every child and young person is as safe and physically and emotionally secure as possible, by minimising risk as much as we can'

Dec 2nd 2011

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INTRODUCTION

This report covers the work of the Local Safeguarding Children Board (LSCB) during 2010-11. It highlights the main achievements in safeguarding Hillingdon's children and young people, and identifies the priority areas for improvement for the following year and beyond.

The main purpose of the LSCB is laid out in 'Working together to Safeguard Children' (Dept of Education 2010). It is the key statutory mechanism for agreeing how organisations in the area work together to safeguard and promote the welfare of local children, and for ensuring that they do so effectively.

The LSCB consists of senior managers and key professionals from all agencies who work with children and young people in Hillingdon. They work together through the Board to make sure that staff are doing the right things to ensure that children are safeguarded. It ensures that key professionals are talking to each other and that children and their families and all adults in the community know what to do and where to go for help. Many of the LSCB's responsibilities therefore consist of setting up and overseeing systems and procedures

The Board regularly checks to make sure these are working well, and that professionals are fulfilling their safeguarding responsibilities effectively. The main focus of our work is to ensure the safety of those most at risk, or potentially most vulnerable. Through this report, and through the Hillingdon Children and Families Trust, the LSCB also recommends appropriate action to ensure that preventative work is identifying and working with those most at risk of future harm.

This year has been one of considerable change resulting from the change of Government in spring 2010. The Munro Review of Child protection and the Government response will require a change of focus towards less bureaucracy and greater focus on professional practice and children's views. There are changes across all agencies, particularly Health and Education, and these, along with considerable resource constraints are a potential risk to our ability to effectively safeguard children. The LSCB must be vigilant to ensure that these changes do not negatively impact on safeguarding children.

A great deal has been achieved by partner agencies in Hillingdon, and this has been confirmed by inspection and audit. However, the potential risks identified above make it even more critical that everyone is working together as efficiently and effectively as they can, and that resources are targeted towards those most in need.

Hillingdon has a population of approximately 264,000 of which approximately a quarter are under 19. This is slightly higher than England and London. There has been an actual and projected increase in numbers of very young children, and a slight reduction in those 10 years and over. About 30% of the resident population, and 49% of the schools population, belong to an ethnic group that is not white British and this diversity is expected to increase, especially among the very young, reaching a projected 50% by 2016.

Hillingdon is a comparatively affluent borough (ranked 24th out of 32 London boroughs in the index of multiple deprivation, where 1 is the most deprived) but within that there is variation between north and south, with some areas in the south falling in the 20% most deprived nationally.

Heathrow airport is located entirely within Hillingdon boundaries and this has a major impact, particularly in respect of children and young people who pass through the airport. Close and effective multi agency work has led to Hillingdon being considered a national leader in the field of protecting children and young people from potential and actual trafficking

During 2010-11 2814 referrals were received by social care of which 2498 received some form of assessment. At 31st March 2011 there were 232 children with child protection plans. This was the same number as in 2010, though there had been an increase in number of referrals and assessments, and those subject to care proceedings.

Lynda Crellin

Independent Chairman

November 2011

WHAT WE HAVE DONE

What we planned to do – our key priorities

Priorities for 2008-11 were developed and agreed in early 2008, and refreshed in 2010 to reflect all the changes contained in the Laming enquiry into the death of Baby Peter.

Seven priority areas of work were identified and these are detailed below with a summary of work completed against those priorities.

Priority 1 Improving infrastructure and functioning of LSCB

- Revised terms of reference agreed and induction sessions established for new members
- The Partnership Improvement plan (PIP) was used proactively to monitor progress against multi agency action plans and reviewed at each Board meeting
- Progress was made on developing the performance profile –e.g. addition of information from A&E
- Annual Report completed and fed into development of the Children and Families plan
- Relationship with schools strengthened through development of SCR action plan. Feedback loops established through the schools representatives on the LSCB, and schools agreed funding for full time post to support staff management in schools

Priority 2 Ensuring effective and improving operational practice

- Performance was good against all national indicators
- Good unannounced inspection of Referral and Assessment with much good practice identified
- In 2010 a team from the Youth Justice Board (England and Wales) validated the Youth Offending Service self assessment of safeguarding practice as Good. In August 2011 Her Majesty's Inspectorate of Probation (HMIP) identified areas for improvement for the YOS which will be overseen by the LSCB
- UKBA inspection achieved Good in relation to aspects of safeguarding children
- Much good practice identified in Health Service Improvement Team (SIT) visit
- Audit completed against revised Working Together and new London procedures issued with guidance and appropriate training
- Guidelines for thresholds for social care developed and issued to all agencies
- Development of guidelines and procedures developed and issued covering complex strategy meetings, health guidelines for working with sexually active young people, updated medical examination and report for child protection enquiries,

- Schools and main statutory agencies asked to complete safeguarding audits to enable LSCB to monitor ingle agency quality

Priority 3 Improving outcomes for children affected by adult issues – particularly domestic violence, adult mental health, substance misuse, including influence of significant males, and working with non compliance

Domestic Violence:

- Drop-in sessions delivered at Uxbridge College and Hayes campus to support young people with emotional issues including DV
- Information and training provided to staff across health agencies

Adult mental health:

- A protocol has been agreed between Children's Social care, and the three Community Mental health teams in Hillingdon.
- Arrangements are also in place for a named link practitioner in Children's social care and Community Mental Health teams in the Borough to offer consultation to each other on relevant issues.
- Community health services (health visitors, schools nurses, community paediatricians) integrated with the mental health provider (Central and North West London -CNWL) thus providing an opportunity to bring children's services together with adult mental health and substance misuse services

Priority 4 Ensuring effective engagement with children young people and their families, and with the wider community

- Pupils trained as cyber bullying mentors and focus group formed
- Children and families fully involved with SCR and informed the action plan
- Regular articles about safeguarding included in schools newsletters for parents
- Some progress achieved on developing the LSCB website

Priority 5 Improving safeguarding for vulnerable groups, or high risk areas

E-safety:

- Cyber mentors have developed a DVD for secondary schools on the risks of 'sexting'
- ICT co-ordinators in schools have been trained and policies and procedures developed for schools
- Cyber mentors trained in schools and a focus group have formed

Trafficking:

- Key role in advising national and international agencies, including peer review at Gatwick
- All time low numbers missing from airport as result of operational meetings

- Operational model replicated for children missing from home care and school

Disabled children and young people:

- NSPCC audit recommendations implemented through Disabled Children Strategy Group
- Increased numbers of disabled children on CP plans at year end. Benchmarking indicates that this is a sign of increased awareness

Priority 6 Ensuring a safe workforce

- Guidance on managing allegations against staff were developed and implemented
- Safer recruitment guidance developed and produced
- Practice guidance was produced for schools to support safe caring issues as identified in the Serious Case Review
- Information was cascaded on the Vetting and Barring Scheme and changes
- Schools agreed funding for complex investigations manager for schools
- Some progress was made in obtaining staffing information for the LSCB but more clarity to be achieved in 2011
- A full programme of multi agency training delivered (54 days, 19 topics, 1211 staff)
- Increased use (1000+) and satisfaction with e-learning

Priority 7 Learning from SCRs and CDOP

- Ofsted evaluation of 'good' for SCR
- Much of the action plan completed
- Schools agreed funding for new post
- Agreed participation in SCIE pilot
- CDOP training delivered to health professionals
- Awareness of key issues delivered through screens at THH A&E, Mt Vernon, Uxbridge shopping centre

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

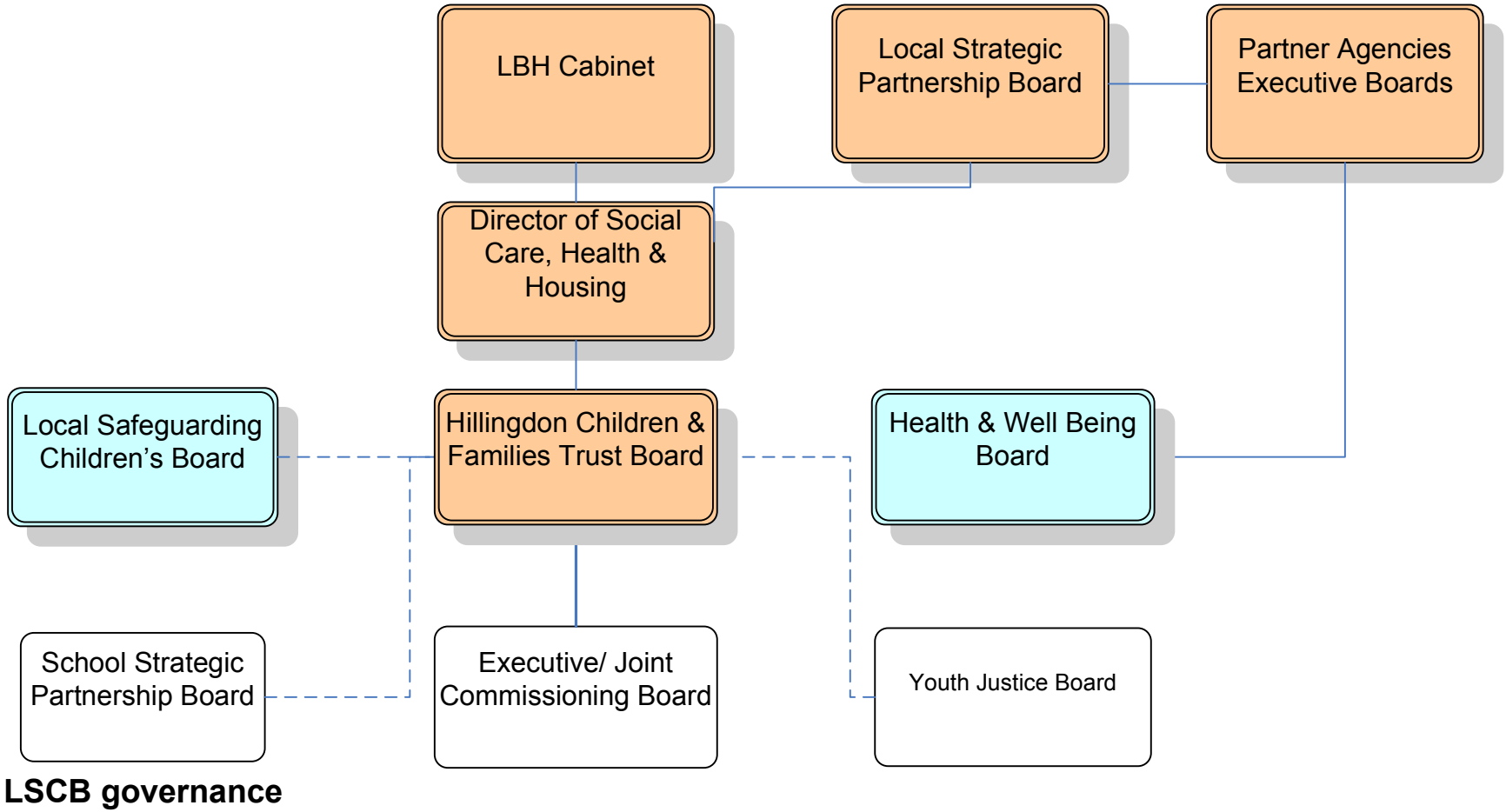
Operation

The LSCB operates in accordance with Working Together 2010. Current local governance arrangements are identified below. There are currently 11 sub groups who meet between Board meetings and take responsibility for actions identified in the Business Plan. The Domestic Violence Forum is a Council led body that sits outside the LSCB governance structure, so joint work is taken forward through the Community Engagement sub group.

Sub group chairs and LSCB officers meet monthly with the chairman to undertake detailed planning for the Board and to monitor progress against the business plan and Partnership Improvement plan (PIP).

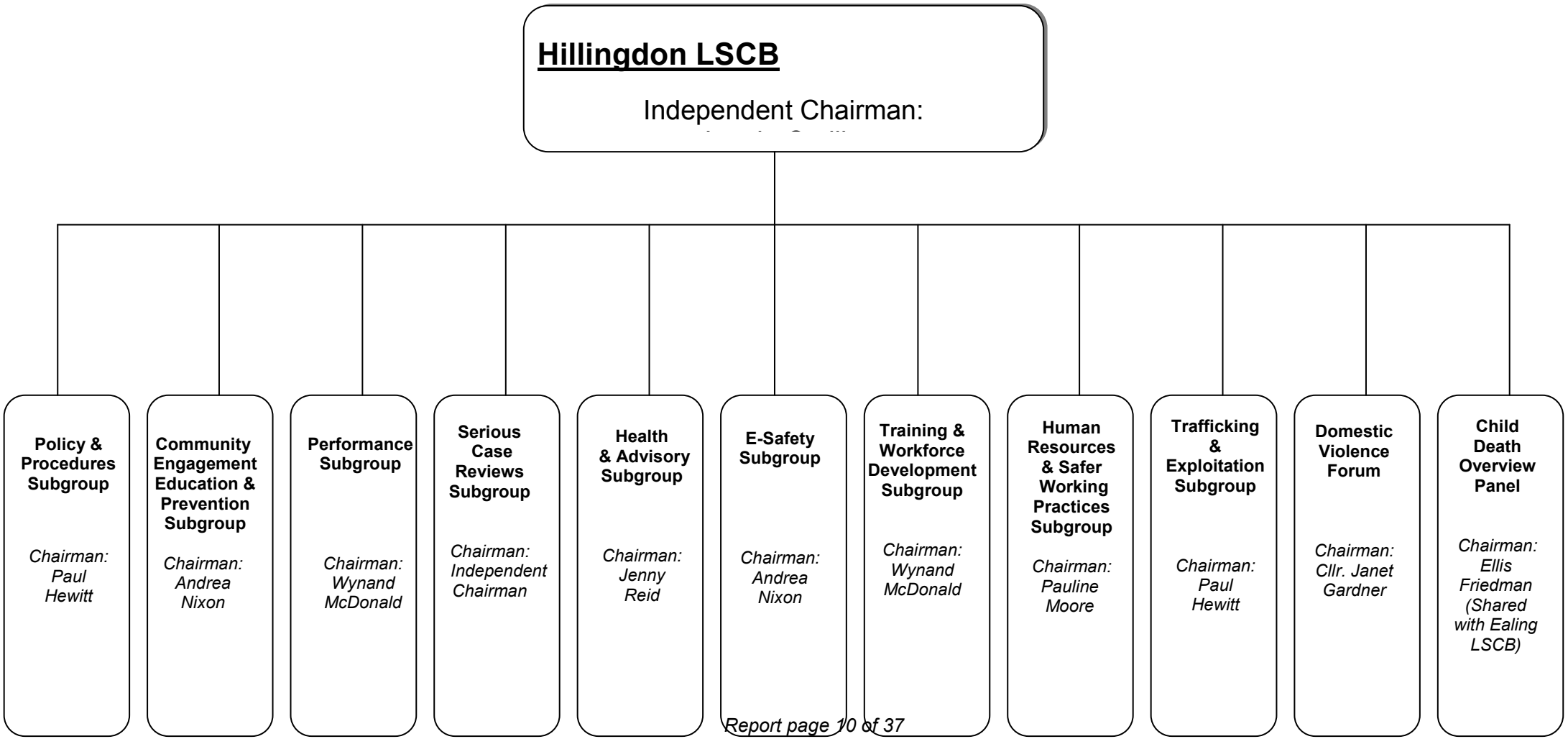
Although there is no longer a statutory requirement to have a Children's Trust, the Hillingdon Children and Families Trust Board (HCFTB) continues to meet in order to oversee the Children and Families Plan. The LSCB chairman sits on the HCFTB and though regular updates ensures that the HCFTB is kept abreast of key safeguarding issues and that these can influence the Children and families plan and the work of the HCFTB.

This annual report will be presented to Council Scrutiny committee and to Cabinet, and will feed into the Local Strategic Partnership Board (LSP) through the HCFTB. Future arrangements may evolve further in accordance with the Munro review which recommends that the LSCB annual report is presented to the Health and Well Being Board and the local Police Partnership Board.



LSCB governance

THE STRUCTURE OF HILLINGDON'S LOCAL SAFEGUARDING CHILDREN BOARD



Membership

The LSCB is a large, inclusive and generally well attended Board, supported by strong sub groups. Overall attendance during 2010-11 was 69%, with Police and CAIT showing 100% attendance and Health and schools 89% and 80% respectively. Local authority showed a lower attendance (55%) due to quite a large number of representatives –but LA senior management attendance was similar to the other main agencies. Low attendees were CAFCASS and Probation due to capacity and number of Boards covered. This will be followed up to try and resolve in 2011-12. The Executive member acts as participant observer on the LSCB in order to ensure he is able effectively to discharge his political accountabilities. He and the Chief Executive attend on an occasional basis and receive papers. Full membership 2010-11 is attached at appendix 1 and will be reviewed in 2011-12 to reduce numbers, and improve attendance through use of deputies where appropriate.

Independent chairman

There is an independent LSCB chairman who operates within a protocol agreed by the Board, and based on that recommended by the London Safeguarding Board. The chairman reports to the Director of Children's Services (DCS) and is held accountable though the Hillingdon performance framework. The chairman meets regularly with the Chief Executive, Executive member, and senior managers from partner organisations.

Relationship to agency boards

Each of the statutory agencies has its own safeguarding governance and audit arrangements, summarised below. Key agencies are asked to complete an LSCB audit each year summarising their internal findings and key issues for the LSCB. Compliance with Children Act section 11 will be tested out across each agency in 2011-12. This will be completed in line with London guidance which is being developed at the request of those agencies that have to complete audits for more than one LSCB.

Hillingdon Council

The Council is represented on the LSCB by the Director of Social Care and Housing (designated DCS) and by the Deputy Directors for Social Care and Education. Most of the statutory indicators for safeguarding rest with social care and these are monitored monthly and also shared with the Corporate Management Team, Chief Executive and Lead Members on a quarterly basis. The Lead Member and Chief Executive receive monthly updates on local safeguarding issues and attend regular safeguarding meetings with senior officers across children's social care education youth and early years services. The Children's Scrutiny Committee reviews key safeguarding areas – the most recent of these being self ham and children educated at home. Recommendations are incorporated as appropriate in the LSCB work plan. This report will be presented to Scrutiny Committee and Cabinet.

Social Care

Social care is developing a quality assurance programme which will report to the LSCB as well as through the internal management line. Social care as the lead agency for child protection has taken responsibility for improving joint working with schools, adult mental health services and the airport. This has resulted in improved identification of children at risk of trafficking, and improved working across agencies. The Ofsted acclaimed work with children on the edge of care has resulted in reduced numbers, though there has been an increase in those going through care proceedings. Reflective practice workshops have improved the quality of supervision and support to front line staff.

Important challenges are to continually improve stability of staffing, to continue close working with schools and other agencies, and to support the continued development of early intervention services through the Team around the Child approach.

From April 2011 children's social care has been managed alongside adult social care and housing.

Education and Early years

The year 2010/11 has been a year of significant change for Education Services and Schools, both nationally and in Hillingdon. Over two thirds of Secondary schools in Hillingdon have now become Academies and operate as independent maintained schools. We expect the numbers of Academies to continue to rise. Currently no Primary Schools have applied for conversion to Academy status. All schools remain represented on the LSCB and HCFTB and work very closely with colleagues in Education and Social Care irrespective of the status of the school.

The Education Bill and changes to the OFSTED Inspection of Schools Framework will impact in 2012.

Education, early years and youth services were managed within a different Council group from April 2011 which makes the joint working that has developed since 2004 even more critical.

Much of the early intervention work takes place in Children's Centres, such as individual and group parenting support, work with those experiencing domestic violence. They work with children who do not meet the social care threshold, and these services are critical in future development of support for young children and their families, but consequentially potentially at risk in the prevailing economic climate.

Specialist education services –particularly Behaviour Support and Special Educational Needs (SEN) work frequently with the most vulnerable and are key members of the multi agency networks. Behaviour Support have been key in working with schools on bullying –an important LSCB issue.

Key issues for the future relate to the increasing independence of schools and the likelihood of more external commissioning of services. Therefore robust mechanisms will need to be in place to ensure safety in recruitment and working practices.

Outcomes of inspections of education and early years settings are reported to the LSCB which monitors resulting actions taken to ensure and improve safeguarding.

Universal and targeted informal education, support information advice and guidance are provided by youth workers and personal advisers. Services are targeted at vulnerable young people during their transition through adolescence to adulthood including those who may be engaged in risk-related activity. This targeted work includes intensive personal adviser support delivered in partnership with service areas working with specific vulnerable groups including looked after young people and young offenders. These services are currently under review given emergent changes in national policy in relation to the provision of careers information, advice and guidance for young people".

Voluntary Sector

The Hillingdon Association of Voluntary Services (HAVS) is represented on the LSCB. The Children Youth and Families Forum (CYFF) are given regular written reports from each LSCB meeting, and are able to raise issues at the LSCB via their representative. In addition, electronic circulation and a newsletter are used to inform all known voluntary organisations of policy updates, training, conferences and consultations as appropriate.

Health Agencies

All the main health agencies are represented on the LSCB, also the Director Public Health (DPH) as safeguarding lead, and designated doctor and nurse. The Designated Nurse is based with Hillingdon Public Health and, alongside the Designated Doctor, has the main responsibility for overseeing safeguarding practice in each health agency. Each Agency has its own safeguarding steering group and these in turn feed into the Hillingdon PCT Safeguarding Group chaired by DPH. Quality assurance work and the monitoring of key actions rest with the health sub group of the LSCB. During 2010-11 a peer review for health was carried out by the Safeguarding Children Improvement Team (SIT) from NHS London. The team found that *'child protection arrangements in Hillingdon are very good, with clear high priority given and good staff'.* Recommended improvements have been included in safeguarding children action plans and these are monitored by each agency's safeguarding committee and at LSCB.

Hillingdon Community Health

Hillingdon Community Health is represented on the LSCB by the Managing Director (who is also deputy chairman of LSCB) and by the designated doctor who remains based in HCH as part of a SLA with the PCT.

HCH is responsible for key groups of staff who are now within the CNWL Trust. Safeguarding governance arrangements remain the same until a satisfactory integration can be achieved. The Managing Director chairs a dedicated Safeguarding Group, which has representatives from relevant clinical and managerial groups, and Hillingdon Hospital. This Group reports directly both to the HCH senior management group and the CNWL Safeguarding Committee.

Along with other agencies the financial climate poses a challenge in ensuring safe practice when the amount of child protection work has increased. The birth rate has increased but health visiting and school nursing staffing has not increased. This will put pressure on universal services.

The Hillingdon Hospitals NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust is represented on the LSCB by the Deputy Director of Nursing.

Safeguarding children arrangements at the hospitals have continued to strengthen during 2010/11. The Executive Director for safeguarding, who sits on the hospital trust board oversees the annual work and audit programmes for safeguarding children and progress against these are reported to the Safeguarding Children Steering Group (SCSG) and the Clinical Quality and Standards Committee (a board committee) on a bi-monthly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2010. The hospitals are well represented on the LSCB and its sub-groups by the hospitals named professionals for safeguarding and senior management staff.

Some of the key developments during the previous 12 months include development of multidisciplinary safeguarding children meetings in orthopaedics and genito-urinary medicine, recruitment of a lead nurse to the children's area in the Accident and Emergency department with recruitment of further children trained nurses to this area, recruitment of a full-time safeguarding midwife role, improved feedback from social services on referrals generated by the hospital and a quarterly safeguarding newsletter that is distributed across the Trust

Key challenges are to ensure compliance with safeguarding training requirements and the maintenance of good safeguarding practice in the midst of financial constraints

Central and North West London Health (CNWL)

CNWL provides adult and child mental health and addiction services across 6 LSCBs, and is represented by the Associate Director for Operations who is also the safeguarding lead. There is an established safeguarding team within the Trust who meet regularly. Hillingdon Community Health joined the Trust in January 2011. Community health has now joined the other services at quarterly Safeguarding Group meetings, which monitors outcome of audits, training, safeguarding policies and procedures. The Safeguarding Group reports to the Board of Directors and links to PCT Safeguarding Group.

The transfer of community health opens opportunities for improved joint working with mental health services but challenges remain. Within mental health, there is a historic under funding of CAMHS and a service review will be undertaken during 2011-12. There are pending changes in adult mental health with a move to payment by results, at the same time the Think Family agenda is one that adult mental health needs to take on board. The financial impact is likely to impact particularly on early intervention services, with a consequential impact on targeted services and possible risks to the ability to provide safe services. This is being monitored within the Trust.

Metropolitan Police

The Police are represented on the LSCB by DCI Public Protection and by Detective Inspector Child Abuse Investigation Team (CAIT). The DCI is responsible for local safeguarding arrangements, particularly CAIT, Public Protection Delivery Team (PPD) Multi Agency Public Protection Arrangements (MAPPA) and the Domestic Violence Unit. He also provides a link with borough policing and Community safety. Relevant statistics are made available to London LSCBs through the Metropolitan Police (MPS) and the framework for ensuring the effectiveness of safeguarding arrangements is delivered through the MPS.

This year the Police worked with the Referral and Assessment Team to assess police notifications using the newly developed Child Risk Assessment Matrix (CRAM). It is too early to assess the impact of this. Another development has been the establishment of a forum with the local authority to consider cases of children who go missing from home or care, and to problem solve key issues. This will be developed further with more comprehensive central analysis around who those are who go missing and where they go missing from.

Locally, the Police have used central funding to develop some programmes for young people. These include a Young Leaders programme to work with those at risk of offending, Rehabilitation theatre workshops to help support young offenders into education or work, and Young Women's programme which will support those most vulnerable as identified by the Public Protection unit.

Child Abuse investigation team (CAIT)

CAIT teams are inspected annually and work to a rolling quality assurance programme which is reported monthly through bi monthly meetings chaired by Commander of SCD 5. Weekly audits are undertaken focusing on risk management, and all crime reports are reviewed on a daily weekly and monthly basis. Police and social care are now working to the Crime Risk Assessment Matrix (CRAM) to try and ensure that relevant high risk cases are picked up. Relevant issues of joint working are brought to LSCB and followed up.

Financial arrangements

The LSCB is funded in partnership by the following agencies:

Hillingdon Council, NHS Hillingdon, Metropolitan Police, Probation, CAFCASS, United Kingdom Border Agency. Between them, the Council and NHS Hillingdon contribute over 90% of the total budget. The Council and NHS also make contributions in kind through LSCB manager, multi agency training, and designated health professionals, plus staff time for training delivery. Capacity is reducing across agencies but multi agency training can only be effective if all key statutory agencies contribute to this. The LSCB budget is sufficient for day to day purposes but has been put under considerable pressure due to a serious case review and further management review, both of which incurred considerable costs for independent reviewers.

LEARNING FROM CASE REVIEWS

Serious Case Reviews (SCRs)

Serious case reviews have to be carried out if a child has died as a result of abuse or neglect, but may also be carried out if a child or children have experienced significant harm, and there are concerns about how agencies work together.

One SCR was completed during this year, and was evaluated as 'good' by Ofsted.

The case related to abuse of children in a school, and there were many lessons learnt about safe working practices and recruitment in schools, as well as improving procedures and processes for investigating concerns and allegations about staff.

The action plan was developed with the support of a small group of school head teachers and governors, and by April 2011 most of the identified actions had been completed. One outcome was the agreement by schools to use some of their dedicated schools grant to fund a full time post to support them in managing allegations and improving safe working practices. All schools are now asked to send a return each year to the LSCB about safe working practices, which will enable support to be directed as necessary to help schools maintain high standards of safeguarding.

Each SCR is based on one case, which always has individual characteristics. However, common features are identified by the Department of Education (DfE) in their biennial reviews of SCRs, the most recent of which covers six years of reviews. Messages from SCRs have been consistent over the six year period. The majority of SCRs concern children under 5, with 45% being under one year of age. This emphasises the key role of universal health services, and early years services, in detecting and helping prevent harm.

But the remaining 25% were mainly older young people who posed a risk to themselves or others, and whose needs are not always recognised. This theme is further explored in the case review identified in the next section. However, neglect was a predominant theme in many cases, along with the 'toxic trio' of domestic violence, substance misuse and adult mental illness.

A further Ofsted report evaluating serious case reviews from April to September 2010 has recently been published. The main themes reflect earlier learning but a particular focus of this report is the lack of attention given to listening to children. There were several areas of concern –that the child was not seen often enough, or asked for their views; that agencies did not listen to adults who tried to speak on behalf of the child; that professionals focused too much on the needs of parents (particularly those most vulnerable) rather than on protecting the child, and that some parents and carers were too easily able to prevent professionals from seeing the child.

Other case reviews

During the course of the year one further case was identified for review. Another local authority referred a case of two young people and queried Hillingdon practice in the case. The SCR sub committee agreed that, although

it did not meet the SCR criteria, it did raise concerns about local practice and agreed that a management review should be carried out. This was completed as part of a London pilot using the systems methodology developed by the Social Care Institute for Excellence (SCIE), and recommended in the Munro Review. The review completes in autumn 2011. Early themes indicate that the methodology promotes useful learning, though it is as resource intensive as a SCR. The findings are due to be discussed at the LSCB in autumn 2011 but some of the preliminary findings indicate that, although many agencies were aware of the family, they did not assess or respond in a holistic or coordinated way, nor was there an effective multi agency mechanism for scrutinising and monitoring high need case that were not child protection. There also seemed to be a failure to recognise and manage chronic neglect. These are familiar themes that have been reflected in other case both locally and nationally. The LSCB and the Children's Trust will develop a response plan when the review is complete and the findings agreed.

Child Death Overview Panel (CDOP)

There was a slight reduction in child deaths, from the previous year and the majority of the deaths were neo-natal, and were non-preventable. However, 6 of the child deaths were deemed to have modifiable factors which may help prevent child deaths in the future. The modifiable factors were mainly in relation to medical care issues which have been followed up.

Further analysis is being undertaken into the demographic factors linked to the neo-natal deaths. For example, the majority of neo-natal deaths in the last two years originated from the Hayes and Harlington wards, where there is generally a higher level of environmental deprivation. It is far too early to draw any conclusions from this data, but there will be some interesting lines of enquiry for Public health and social care services.

WORKFORCE

Evaluation of single and multi agency training

The LSCB continued to offer core safeguarding training to all agencies. Participation in the e-learning module on *Introduction to Safeguarding Children* has shown a year-on-year increase of almost 140% (630 to 1511 participants). This is a very welcome development, especially because this mode of learning is cost-effective and reaches hitherto hard to train groups such as frontline teachers.

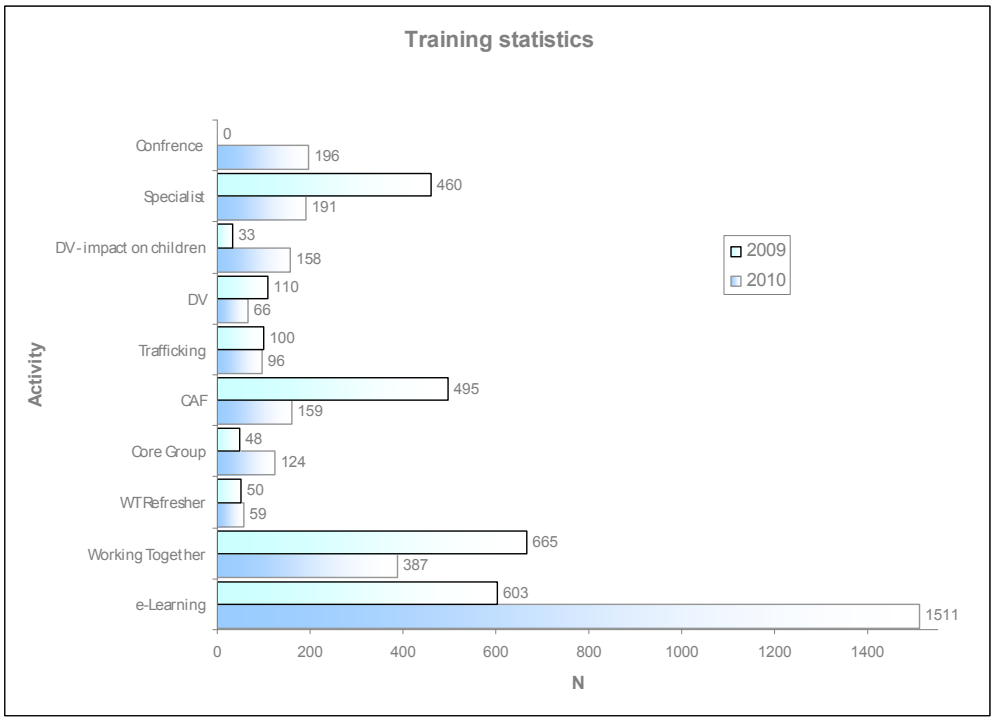
Regrettably, fewer practitioners have taken up the opportunity to attend multi-agency *Working Together* training which has slipped from 665 to 387 participants, nearly 42%. This tendency was partly expected because the previous year's figure was unusually high after the death of Baby Peter. Strict training policies in the NHS have meant an initial increase in attendance of the LSCB's health partners but because saturation levels are now being reached attendance is also slowing. Refresher training is mostly attended by named and designated professionals showing a slight increase of 18% but in absolute numbers that meant only 9 more participants.

Named and designated nurses as well as the Education Officer for Education have worked hard to improve the quality and attendance of core groups. Working Together training has also been re-designed last year with aim to focus on more relevant staff who are likely to attend case conferences or become responsible for child protection plans. This strategy has paid dividends with participation in Core Group training increasing by 158%.

As before, the LSCB offered a mixed menu of courses in line with the LSCB priorities including Domestic Violence, Child Trafficking, Neglect, Impact of Adult Mental Health on Children and recommendations from the serious case review of Mr X. Financial pressures, however, meant focussing on priorities; as a result other specialist training has more than halved (58%) from 460 places to 191.

Over 700 multi agency practitioners are trained in CAF and the demand in training has deceased accordingly. Ad-hoc training sessions are currently provided when requested for new members of staff.

Overall, the LSCB has trained nearly 3000 members of staff which is an increase of 14% over the previous year. Mostly, staff attend courses they have identified which is an improvement over the previous year when there were some difficulties with non attendance.



Capacity

All agencies have experienced financial reductions and some consequential staffing reductions as a result of the economic downturn. In high risk areas numbers of front line staff have been maintained but workloads have continued to increase and reductions in non frontline staff have had an inevitable impact on their work. In other areas staffing has remained the same but responsibilities have increased and/or management post and therefore oversight has been reduced.

There have also been structural changes which may impact on safeguarding. A reduction in Council senior management has resulted in children's social care coming under the same management structure as adult social care and housing. This has positive aspects, but they are no longer based with education and early years services in a dedicated children's department. Changes in the PCT towards a commissioning only service have resulted in community health services coming under the management of CNWL. There have been no reductions in designated or named safeguarding professionals within health.

The Board receives some staffing information but is trying to develop a better system to facilitate effective monitoring of the impact of staffing changes on safeguarding children.

There has been a reduction in the number of social work post vacancies and the number of agency staff, both at practitioner and manager level, thus improving the stability of the workforce.

There has been a dramatic reduction in midwife vacancies with 17 in January 2010 reducing to 8 in January 2011 and none by October 2011. Whilst recruiting, vacancies are filled by bank and agency staff to maintain the required staffing ratios.

Allegations

The recommendations from the serious case review relating to Mr X have been implemented. The delegated Local Authority Designated Officer (LADO) role for schools was filled with the post holder commencing in April 2011. The post holder is now the single point of contact for allegations of abuse or concerns about staff working with children in education settings and other child related services in the Borough.

The LADO chairs all Complex Strategy Meetings and provides consultation and guidance to schools when concerns arise that do not meet the threshold for a meeting. The LADO is also the point of contact for the Independent Safeguarding Authority and will liaise with Ofsted when allegations arise in early years settings.

All schools have been informed of the function of the LADO and are utilising the services of the post holder appropriately on a frequent basis.

Final strategy meetings/discussions are now being held on all cases and the LADO continues to liaise with CAIT police where there are criminal proceedings that continue for lengthy periods after the initial child protection enquiry has been concluded. This enables outcomes to be formally recorded for future reference. Further work is being undertaken to devise an Allegations Management database system for the more concise recording and monitoring of cases.
The number of allegations against professionals for the period [April 2010-March 2011] totalled 78, 43 of which related to education settings. Looking at the current figures for the period April 2011 to date, it is envisaged that the number of allegations has increased from last year, as have the requests for consultations on concerns that do not meet the threshold for a strategy meeting.

A positive working relationship has been maintained with the Schools HR department whom, whilst operating independently of the local authority, continue to provide a service to the majority of schools in the Borough and are working effectively with the LADO in support of their staff at strategy meetings.

School staff have been briefed extensively on the outcomes and recommendations of this serious case review and relevant training and advice is provided by the Designated Child Protection Officer for schools. There is an accessible rolling programme of School Governor training on safer working practice and safer recruitment. An e-learning module has been devised, which will be rolled out in the late autumn, covering all aspects of learning, including the key messages from the serious case review.

HOW WE ARE DOING: effectiveness of local safeguarding

How the LSCB monitors local safeguarding arrangements

The LSCB has put various mechanisms in place to assess individual and multi agency performance.

The Partnership Improvement Plan (PIP). This is a reactive work plan that responds to actions arising from inspections, case reviews, audits etc. Regular monitoring ensures that the LSCB can be assured that relevant single and multi agency actions are completed.

At the start of the year there were 50 open actions on the PIP. During the year a further 114 actions were added, including 64 from the Serious Case Review. 140 were completed, leaving 24 in progress at the end of March 2011.

Performance Profile. This is a report that summarises performance against national and local indicators, plus inspection reports across all agencies. It is presented at each Board meeting and enables the LSCB to monitor progress and take action as appropriate.

Business plan and sub group action plans. Sub group action plans are reviewed at business meetings between Board meetings and feed into the end of year review of the LSCB business plan.

Audits. Each agency carries out a programme of internal audits. Key actions are fed into the PIP and also reported annually to the LSCB. The main statutory agencies are asked to complete an annual return to the LSCB identifying their internal audit programme and consequential actions taken. Following the serious case review schools are now asked to complete an annual safeguarding audit for the LSCB. These are reviewed by the performance sub group.

Action plans arising from Serious and other case reviews and Child Death reviews feed into the PIP to ensure that progress is monitored

The LSCB provides a quarterly update for the Children's Trust and, through attendance of the chairman, is able to influence the Children and families Plan, particularly development of preventative services.

Effectiveness of local arrangements to safeguard children

The LSCB's monitoring activity has enabled us to comment on the effectiveness of local safeguarding arrangements:

Inspections and other external validation

The Ofsted Annual Children's Performance Assessment for the year 2010-11 judged that children's services in the London Borough of Hillingdon perform well. 'This performance has been sustained from 2010 to 2011. The majority of services, settings and institutions inspected by Ofsted are judged good or outstanding and few are inadequate. Most are good at keeping children and young people safe'

Unannounced inspection of Referral and assessment services completed in February 2011, found that the frontline child protection services were safe, and had some outstanding features around initial assessments and decision. Areas for development included more consistent use of the threshold policy across partner agencies, and improvements in the use of chronologies. These issues have been covered in subsequent action plans monitored by the LSCB.

The YOS Core Case Inspection took place between 25th and 28th July 2011 led by Her Majesty's Inspectorate for Probation (HMIP). The inspection included an evaluation on how effective the YOS is in safeguarding and identified that substantial improvement was required.

Within the YOS inspection framework references to 'safeguarding' include both welfare and safeguarding matters although the current policy direction from central government is about focussing on child protection, as opposed to the wider definition of child safeguarding, The commentary and findings in the YOS inspection report would appear to suggest that child protection activity and co-work with social care was well evidenced. However activity on the wider welfare issues was less well documented.

The inspection report also acknowledged that the YOS had undertaken a service review in late 2010 and that changes had been implemented for new cases from February 2011 but this was too late for the sample inspected. The report notes these provide a framework which alongside the improvements identified to address the issues identified in the inspection, would suggest there are encouraging prospects for improvement.

UK Border Agency had a routine inspection during the year. The conclusion was that the UK Border agency was meeting its safeguarding duties and obligations under section 55 of the Borders. Citizenship and Immigration Act 2009.

An area for close monitoring was that of ensuring that children and families are not kept in the Holding areas of the airport terminals for more than 24 hours. This is now monitored by the Local LSCB in Hillingdon; especially in relation to the airport terminals.

Hillingdon took part in an Ofsted inspection/survey focusing on Children on the edge of care on 15th/16th June 2011. Hillingdon has been consistently rated good or outstanding in this area of work, with a sustained reduction of the number of children in care. Hillingdon's work was validated and confirmed by the Ofsted inspectors, who found clear improved outcomes for the children and families who participated in the inspection. The inspectors commended the strong collaborative working of the partner agencies in Hillingdon, and the "stickability" of the practitioners who intervened decisively with these families to help keep the children at home. Hillingdon's model of intensive family support will be cited in Ofsted's final research paper on this area of practice, due to be published in the Autumn 2011. The emphasis on early intervention is likely to be highlighted in this report. This will be included in Hillingdon's multi-agency Family Interventions Programme, which is currently being pursued to help organize services more efficiently to avoid duplication.

- There have been 285 inspections of childcare from 1st September 2008 to 31st March 2011 with 6% being rated outstanding, 55% good, 35% satisfactory and 4% inadequate for overall effectiveness.
- In terms of the effectiveness of safeguarding in childcare provision, performance was above overall effectiveness with 7% being judged outstanding, 59% good, 31% satisfactory and 4% inadequate. Of the inadequate judgements, 7 childminders and 1 group provider were issued with actions in relation to safeguarding and all received support from the Childcare and Early Years Service. Most actions related to inadequate standards of record keeping or failure to attend training prior to registration. Improvement plans were drawn up by the C&EY Service and regularly monitored for compliance. Nationally 15% of all actions from childcare inspections were in relation to safeguarding and welfare.

NHS London SIT visit: the team found that *'child protection arrangements in Hillingdon are very good, with clear high priority given and good staff'.* Recommended improvements have been included in safeguarding children action plans and these are monitored by each agency's safeguarding committee and at LSCB.

At time of writing this report, Hillingdon was taking part in a pilot inspection of child protection services. This was carried out by Ofsted in order to test out the new methodology which reflects the recommendations contained in the Munro review. Some recommendations are emerging which will be appropriately reflected in the LSCB Business Plan and monitoring activity.

Child protection activity

There has again been an increase in referrals to social care rising from 2300 last year to 2814 in 2010-11. This increase was reflected across all the main agencies and resulted in an increase in both initial and core assessments, along with an increase in the proportion of those completed within timescales. This reflects both a greater awareness of child protection issues, and a rising birth rate.

.The number of children on child protection plans has remained constant, as has the average time spent on plan (9.5 months), after an increase the previous year. There are significant numbers on plan for emotional abuse (28.4%) and neglect (41.4%) reflecting national trends. However, evidence from national and local cases indicates that more needs to be done to ensure that cases of neglect and emotional harm are identified earlier and responded to appropriately.

There has been an increase in the number of care proceedings initiated which has become more marked in the current year (2011-12). Clearly appropriate action is being taken in the case of those families where children are likely to remain at risk of significant harm.

Trafficking

The three tier model for combating child trafficking has been commended by the Home Office, and included in the National Strategy published in July 2011. This model includes fortnightly operational meetings identify children who may be at risk of trafficking or going missing. By this mechanism the total number

of children who went missing has been reduced considerably from 24 to 8 during the year

An area for development is the trafficking and sexual exploitation of children and young people within country. Regular operational meetings with Borough Police have been set up to share intelligence and assess the needs of local children who may be at risk of going missing or sexual exploitation or intimidation from local gangs.

Private fostering

Across agencies there is evidence of raised awareness about the identification of children who are privately fostered. This is particularly true for partner agencies such as UKBA and schools, where training on private fostering has been rolled out throughout the year. Despite the slight increase in numbers of children who are privately fostered in Hillingdon [10 children this year -7 in the previous year], this remains an area for further local development, as it is nationally. [According to the Governments statistics there are approximately 1,400 privately fostered children across all Local Authorities. It is estimated by BAAF that there are as many as 10,000 children privately fostered in the UK].The LSCB in Hillingdon will continue to raise awareness about this key safeguarding issue.

Disabled children.

There was an increase in the number of disabled children on child protection plans. This is evidence of increased awareness of safeguarding following the audit undertaken in 2009-10. The CWD service has shown more a greater ability to support parents with disabled children, whilst being robust in applying thresholds of child protection.

Looked after children
The number of children in care reduced during 2010-11 from 438 to 384. This included both local children and those who arrived unaccompanied at Heathrow. The majority of those coming into care were up to 5 years of age, although there was also a small but significant number aged 13-16. This reflects the work undertaken in ensuring that the right children are safeguarded through coming into care. The teenagers brought into care are those who have been seriously exploited outside the family home. The increase in younger children coming into care represents a proactive approach to permanency, and ensuring that the most vulnerable children are being protected through the care system.

Young carers

Raising the awareness of young carers is a vital part of the LSCB's role. Young carers - children and young people aged under 18 - must not carry out inappropriate levels of care and should be able to fulfil their own aspirations. Protecting this vulnerable group remains a key priority.

Recent national figures reveal an alarming increase in the number of children under 18 providing care within their family. In 1996 it was estimated that there were 51,000 young carers. This has now nearly tripled to 149,000. The real figure could be much higher as many families do not recognise the caring tasks that a child is taking on and therefore do not publicly acknowledge it.

There continues to be a rise in the number of young carers in Hillingdon. There are currently 270 registered carers, which is a rise of 41 from the previous year.

The Local Authority has produced a poster, designed with help from our Young Carers' group, which is focussed on reaching young people who don't recognise themselves as having caring responsibilities. The poster signposts to the range of support available to them from Hillingdon Carers. The poster has been circulated to schools, colleges, GP surgeries, libraries and other community organisations.

Children who experience domestic violence

These continue to form a high proportion of those with child protection plans, and many of them also come from families where substance misuse and/or metal illness are present. During the year 554 children were known to the Independent Domestic Violence Advocacy Project (IDVA) –this is likely to be a considerable under estimate as it does not include those families considered standard risk. It is well known that all children who experience domestic violence are at risk of potentially damaging emotional harm and those who do not come to the attention of services may well live with the issue for a longer period. Support for these children remains a priority for the LSCB and the Children's Trust.

Serious case Review

All the identified actions from the Serious Case Review were completed by year end. There is anecdotal evidence that implementation has been carried through into practice – improved identification indicated by increased referrals to LADO, procedures followed in strategy meetings, evidence from schools audit. Processes have been put in place to enable the LSCB to ensure that actions are fully embedded into local practice.

The removal of the TELUS survey means that the LSCB has less access to information from children and young people. Shortage of information from children and their families is an important gap in the LSCB arrangements which will be addressed in our new planning from 2011 onwards.

Much useful learning came from two case reviews –the SCR and the SCIE pilot case. However, the time taken up by these cases meant that the LSCB was unable to progress any formal action relating to assessment of the quality of day to day multi agency practice. Again, this is addressed in our planning for 2011. However, information from inspections (see above) and some anecdotal cases that are reported to the LSCB, indicate that there is much sound practice at the front line, and a willingness among professionals to swiftly address concerns about practice when they occur.

In the last annual report the LSCB raised concerns about the deficiencies in identification and support for children and young people who suffer emotional harm. This remains an important theme in this report. It is a strong emerging issue in the SCIE pilot case, particularly in respect of CAMHS provision. The shortage of CAMHS provision was also highlighted by health and education agencies in their audit responses. CAMHS provision in Hillingdon is comparatively poorly funded.

Overall, the LSCB is confident that safeguarding practice in Hillingdon remains good, supported by strong multi agency partnerships. However there are some important potential risks to maintaining this position.

Potential risks to safeguarding

Resources. The biggest risk, as ever, is the availability of staffing capacity when measured against workload. Although agencies have had notable success in increasing the stability and ability of the workforce, staffing numbers have not kept up with the increase in child protection work, and the rising birth rate. This will now be exacerbated by the financial climate and an inevitable reduction in services for non targeted and non specialist work. The LSCB receives information about staffing and is trying to improve the effectiveness of its monitoring arrangements.

Re-organisations. Most agencies are carrying out some reorganisation with the aim of improved efficiency. However successful, the actual process of reorganisation creates uncertainty with the consequential risk that safeguarding issues may be missed. Relationships may be harder to maintain if management lines change. Agencies feed back to the LSCB on a regular basis on progress, but the impact of reorganisations ad cost savings are as yet hard to assess.

Lack of coordination of early intervention work. Evidence from the SCIE pilot and other case work indicates that support services are not always planned and delivered in a coordinated way. This is partly due to the differential processes that apply within each agency. The LSCB will inform the future development of early intervention services through the Children's Trust

Heathrow. The presence of Heathrow Airport within the Borough boundaries poses particular risks in respect of a transient population, particularly those at risk of trafficking and exploitation. This has been mitigated by effective and organised multi agency cooperation and action which has reduced the numbers of children and young people at potential risk.

Gaps in LSCB quality assurance mechanisms. The LSCB has been able to assure itself of the effectiveness of internal agency audit work, and through case reviews has some awareness of system deficiencies. However, further work is needed to ensure that the LSCB can confidently assess the child's progress through the system though a multi agency quality audit system and ways of obtaining views of children and their families. This is addressed in the LSCB action plan.

Potential opportunities to improve safeguarding

Staffing. On the whole children are effectively safeguarded in Hillingdon through the efforts of skilled and hard working staff. The LSCB will continue to ensure the delivery of a strong multi-agency training programme and will do more to engage with staff and obtain their views.

Reorganisations. Although a distraction, there are some potential gains in multi agency working though closer links between children and adult services which have come about in both social care and community health.

The Munro Review. If the Munro recommendations are implemented, the process of assessment should be more continuous and based on cumulative

assessment of need, and the exercise of professional judgement, rather than being constrained by artificial timescales and targets.

Hillingdon Family Intervention Project. This is a developing project which aims to use available early intervention resources to provide a coordinated response to children in need and their families. This does provide a potential opportunity to provide early interventions to ensure that issues are addressed before the child protection threshold is reached.

Ofsted new inspection framework. This is based on the Munro report, and will be unannounced, and based more on the child's journey. If it works, it will involve much less prior work and be a more realistic assessment. Hillingdon will be one of six areas piloting this approach. Unfortunately, there is at present no plan for the Care Quality Commission or other relevant inspectorates to be involved in a concurrent inspection as previously, which raises concerns that it will focus on the local authority more than other agencies, and miss opportunities to assess the effectiveness of early intervention work.

NATIONAL AND LOCAL CONTEXT: implications for safeguarding

The Eileen Munro review of child protection.

The Munro Review of Child protection was published in May 2011 and an initial Government response appeared in July 2011. The review is available from the DfE website

Professor Munro made many recommendations which are intended to reduce bureaucracy by removing many prescribed targets, and focusing more on professional judgement backed up by research and impact on children and their families. She emphasises the importance of early help to families to address problems before they escalate to child protection concerns. She also recommends a different form of inspection focusing more on feedback from families.

The Government has accepted the recommendations and has set up an Implementation Working Group to develop their response. The Government has committed to reducing central regulation and slimming down current guidance on assessments. A joint programme of work with the Dept of Health will ensure that children's safeguarding is a central consideration of health reforms instead of current processes. Further consideration will be given to using systems methodology (as used in SCIE pilot) for SCRs.
Ofsted are consulting on a new framework for inspections which will be unannounced and will focus more on impact on children and their feedback.
A small amount of funding has been provided in 2011-12 to facilitate the development of principal social worker, provide support for early help and training and development activities of LSCBs.
Government response to the Munro review (PDF)

National Health Service

The Health Service is facing significant organisational and financial challenges. The health Bill will lead to Public Health moving to the Borough in 2013 and increased commissioning responsibilities for GPs. The precise implications of how child safeguarding will be affected by these organisational changes are unclear. In the interim, liaison arrangements between the various health organisations in Hillingdon remain strong. The Hillingdon PCT has become part of a de facto new PCT –Outer West London, joining with Ealing and Hounslow PCTs. This grouping is itself responsible to another new 'cluster' PCT -North West London PCT.

A Hillingdon Clinical Commissioning group led by local GPs has been set up with the Director Public Health as a member. The Health and Wellbeing Board is charged with developing an overall Health and Wellbeing Strategy for the population. Senior Managers across all the partner agencies attend both the LSCB in Hillingdon and the Health and Well-being board. This ensures that the child safeguarding agenda is kept as a high priority in the commissioning of children's services in health and social care.

Health, along with other public sector agencies, is facing financial challenges. However, safeguarding remains a priority area and local resources in respect of designated and named professionals have remained the same.

Education changes

The Education Act received royal assent in November 2011. The LSCB is pleased to note that the Children Act duty on schools to cooperate with the local authority to promote children's welfare, remains in place.

The Department for Education with the Department for Health consulted on the Special Educational Needs and Disability (SEND) Green Paper during summer 2011. The Government has now announced that pathfinders will test out the main proposals during 2012-13. The pathfinders will all test some core elements of reform, including:

- a single education, health and care plan from birth to 25 years old, focusing on whether outcomes for disabled children and their parents have been improved
- personal budgets for parents of disabled children and those with SEN so they can choose which services best suit the needs of their children
- strong partnership between all local services and agencies working together to help disabled children and those with SEN

In spring 2011 Hillingdon Council re-organised and children's social care moved to be with Adult Social Care and Housing. Education, early years, youth services and schools are now in Planning Environment Education and Children's Services (PEECS).

There are potential gains from these changes, particularly closer links between children's social care and adult services and housing. There should be opportunities for a more cohesive approach to social work development.

At the same time, it will be vital to ensure that the close working built up across all children's services since 2004 is not lost. Schools and education/early years services are committed members of the LSCB and the Children's Trust and these should ensure that safeguarding and joint working remain high priorities

In early 2011 the Department of Education (DfE) published a summary of 15 research studies into safeguarding. These studies were jointly sponsored by the DfE (then DCSF) and the Dept of Health. The summary is available from the DfE website

The findings corroborated many of those emerging from serious and other case reviews:

- The long term corrosive impact of abuse and neglect, particularly among adolescents, is not sufficiently recognised and addressed
- It is possible to provide validated programmes of help, but families often need longer term support to avoid breakdown or further damage
- Insufficient clarity among agencies over thresholds

- The benefits that can be achieved by proactive social work based on sound assessments and planning, and informed by knowledge of child development
- Evidence that families who fall below social care thresholds do not receive sufficient help, both before and after social care interventions. Close working between targeted services and GPs is needed
- There should be stronger links between those working in adult and children's services, particularly in respect of domestic violence, substance misuse and mental illness
- There have been improvements in inter-agency and inter-disciplinary working, some as a result of effective inter-agency training. There are concerns that proposed reforms to the NHS and schools and measures to restrict public spending might unintentionally have a negative impact on these advances.

WHAT WE NEED TO DO: priorities for LSCB 2011 onwards

Our evaluation of the progress against our priorities plus our assessment of the effectiveness of local safeguarding arrangements, and consideration of relevant national issues, has led us to identify the following main priorities for the Board's work from 2011. These are detailed in the LSCB Business plan 2011-14 and include:

Priority 1 Improve LSCB functioning

- Implement Munro recommendations and Government requirements as required
- Improve links and synergies with Safer Adult Partnership Board
- Find ways of assessing LSCB effectiveness
- Incorporate views of children, young people and their families in the work of the LSCB
- Incorporate the views of staff in the work of the LSCB
- Improve ways in which the LSCB communicates with professionals and the local community
- Continue to improve data information available to the LSCB
- Improve engagement with GPs

Priority 2 Assess and improve operational practice

- Ensure all agencies fully understand the social care threshold criteria
- Carry out and report on single agency audits
- Develop and learn from a multi-agency quality audit programme for the LSCB

Priority 3 Improve outcomes for children affected by key risk issues

- Monitor and improve outcomes for children affected by:
- Trafficking, going missing, or private fostering
- Domestic violence
- Adult mental illness and/ or substance misuse
- Online bullying or exploitation
- Sexual exploitation
- Being educated at home

Priority 4 Ensure a safe workforce

- Ensure support and training for those in universal services
- Develop ways of assessing access to and impact of training
- Enhance support to front line managers
- Improve responses to allegations against staff

Priority 5 Learn from Case Reviews

- Complete Serious case review implementation
- Complete SCIE pilot and implement action plan
- Ensure effective CDOP arrangements under reduced resource availability

RECOMMENDATIONS TO THE CHILDREN'S TRUST

Comment on needs assessment

There is a current and projected increase in the birth rate. At the same time staffing in key services (health visiting, school nursing) has remained the same, and there is potential threat to funding for children's centres. Child protection work has increased but a strong message coming from SCRs and research emphasises risks to very young children. This is supported by local figures on numbers on child protection plans and coming into care. This makes it critical that there are effective mechanisms for identifying early those in need of targeted support, and providing those services to prevent them reaching child protection thresholds. At time of writing the Coalition Government has indicated that there will be an increase of 50% nationally in the number of health visitors, and Hillingdon is an early implementer of the parent partnership scheme. The LSCB welcomes this as health visitors are a critical element in safeguarding children under 5 years of age, and an important resource in terms of early intervention. However, commissioning arrangements locally are unclear

Hillingdon has 30% non white population and this is rising. This creates potential for inequalities and there are some safeguarding issues that are particularly relevant to some ethnic groups, e.g. female genital mutilation, forced marriage, stigma and low reporting of domestic violence and mental health issues. These will be monitored as appropriate through LSCB performance information and the work plan.

Child and Adolescent Mental Health Services (CAMHS). Comments have already been made about the comparative low level of funding compared with other boroughs. There is a shortage of tier two services to meet the needs of children experiencing emotional harm. In view of the high numbers of children experiencing neglect and emotional harm, provision of appropriate support at an early stage is critical in terms of well being and preventing future harm.

Key messages

In the current financial climate all agencies must try as far as possible to protect front line services, particularly those involved in protecting children from harm, and develop ways of assessing the impact of any changes on safeguarding. Sound multi agency working and information sharing become even more critical at times of scarce resources.

There is a need for coordinated early intervention services with clear pathways and a system for high need non child protection cases that should reflect the child protection system with lead professional and coordinated plan. The Family Intervention Project has the potential to achieve this, but it must be multi agency and should focus on those most at risk, based on LSCB information, and on interventions that are known to work. There should be clear pathways that bring all relevant agencies together to ensure that the most effective plans and services are provided, and that most effective use is made of scarce resources.

Very young children remain the most at risk group. However, SCRs and local experience reveal also a high level of need among adolescents and that is the time when long term neglect becomes apparent, when problems are often most intractable and solutions outside the family less likely to work. Developmentally some problems that arise in the early years can be resolved in early adolescence, so a targeted approach to young people in or soon after transition from primary to secondary school is recommended. This should be included in the planning for early intervention services.

It is critical that commissioners review the funding and provision available for mental health services, particularly CAMHS, though adult mental health services are also highly relevant. These services should link with early intervention services, and not just be available at high levels of need or in the case of diagnosed mental disorders. As indicated earlier the LSCB would like to have stronger links with commissioning decisions, particularly Health, and the health and Well Being Board could be an appropriate forum alongside the Children's Trust.

APPENDIX 1: LSCB membership

Chairman and officers of the LSCB

- Lynda Crellin - Chairman [Independent]
- Maria O'Brien - Deputy Chairman [Managing Director, Provider Services, Hillingdon Primary Care Trust]
- Paul Hewitt - LSCB Lead Officer
- Wynand McDonald - LSCB Training and Development Officer
- Carol Hamilton - Manager, Child Death Overview Panel (CDOP)
- Andrea Nixon - Schools Child Protection Officer
- Stefan Szulc - LSCB Legal Advisor
- Julie Gosling - LSCB Administrator

Observers

- Cllr David Simmonds - Deputy Leader of the Council & Cabinet Member for Education & Children's Services
- Hugh Dunnachie - Chief Executive, London Borough of Hillingdon

Local authority representatives

- Linda Sanders - Director of Children's Services and Corporate Director Social Care, Health & Housing
- Merlin Joseph - Deputy Director, Children & Families, Social Care, Health & Housing
- Anna Crispin - Deputy Director Education, Planning, Environment, Education & Communities
- Sue Drummond - Head of Sports & Leisure Services
- Tom Murphy - Head of Youth & Connexions, Planning, Environment, Education & Communities
- Lynn Hawes - Service Manager, Youth Offending Service, Social Care, Health & Housing
- Parmjit Chahal - Service Manager, Family Support Services, Social Care, Health & Housing
- Alison Booth - Child Care and Early Years Manager Social Care, Health & Housing
- Nick Ellender - Service Manager, Safeguarding Adults, Social Care, Health & Housing

Health representatives

- Maria O'Brien - Managing Director, Provider Services, Central North West London Trust
- Ellis Friedman - Joint Director of Public Health, LBH and Hillingdon PCT
- Jacqueline Walker - Deputy Nurse Director, Hillingdon Hospital NHS Trust
- Catherine Knights - Director of Operations Central North West London Trust

- Chelvi Kukendra - Designated Doctor, Hillingdon PCT
- Jenny Reid - Designated Nurse, Hillingdon PCT
- Abbas Khakoo - Named Doctor, Hillingdon Hospital NHS Trust

Police and probation representatives

- Tariq Sarwar - Detective Chief Inspector, Hillingdon Borough Police
- Dave Franklin - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police
- Sharon Brookes - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
- Marcia Whyte – Assistant Chief Officer, London Probation

School representatives

- Sue Gould - Head teacher, Vyners School
- Catherine Moss - Head teacher, St Bernadette's School
- Joy Nuthall - Head teacher, Moorcroft School

Other representatives

- Gavin Hughes - Deputy Principal Officer - Uxbridge College
- Rose Alphonse - Uxbridge College Children's Centre
- Fiona Miller - Children, Youth and Families Officer, Hillingdon Association of Voluntary Services
- Nicola Cruickshank - Service Manager, CAFCASS
- Arlene Weekes - Director, In The Spirit Ltd.
- Stephanie Waterford - Licensing Services Manager, Environment & Consumer Protection Services LBH
- Tim Reichhardt - Regional Director UKBA
- Jo Wrath - Principal Support & Welfare officer SSAFA
- Tom Buckley - Service Delivery Manager, Heathrow Airport Detention & Escorting, G4S Care & Justice Services (UK) Limited

APPENDIX 2: Glossary

A&E	Accident and Emergency Services
CAF	Common Assessment Framework
CAIT	Child Abuse Investigation Team (Metropolitan Police)
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CNWL	Central and North West London Trust
DCS	Director of Children's Services
DfE	Department of Education
DPH	Director of Public Health
GP	General Practitioner
HCFTB	Hillingdon Children and Families Trust Board
HCH	Hillingdon Community Health
ICT	Information and Communication Technology
LADO	Local Authority Designated Officer (allegations against staff)
LSCB	Local Safeguarding Children Board
LSP	Local Strategic Partnership
NSPCC	National Society for Prevention of Cruelty to Children
PIP	Partnership Improvement Plan
PCT	Primary Care Trust
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SEN	Special Educational Need

SIT	Safeguarding Improvement Team (NHS London)
THH	The Hillingdon Hospital
YOS	Youth Offending Service
UKBA	United Kingdom Border Agency