Hillingdon Local Safeguarding Children Board

Annual Report

2012 – 13

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

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1. INTRODUCTION

This report covers the work of the Local Safeguarding Children Board (LSCB) during 12-13, plus any significant developments that took place in the early part of 2013-14. 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 2013). 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. This latest version of the statutory guidance, based on the outcome of the Munro Review, was long awaited. It has changed much of the framework in which we work, and has given more authority to LSCBs in monitoring both child protection and early help services.

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.

The year has been characterised by huge change and upheaval in partner organisations, which has continued into 2013. Although the number of children with child protection plans has stabilised, it has been at a higher level than in previous years and the workloads have remained high. There is evidence of strong practice in many areas but the challenging problems of domestic violence, mental health problems among both parents and children and difficulties in identifying and resolving long standing neglect remain. In addition, national cases have focused our minds on important issues such as sexual abuse and exploitation.

A great deal has been achieved by partner agencies in Hillingdon, and this has been confirmed by inspection and audit. All agencies demonstrate a strong commitment to safeguarding. 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 is the second largest of London's 32 boroughs. It had a population of approx. 273,900 at mid 2012 of which just over a quarter were under 19.

This proportion is slightly higher than England and London. There has been an actual and projected increase in numbers of very young children, and families with the 5-9 age group projected to rise the most over the next few years. However, these growth rates are not very different from London as a whole. 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 2012-2013, there was a 26% increase in the number of contacts (12,147) compared to the previous year (2011-2012). However, the number of these contacts being treated as referrals showed a 13% reduction. This was due in the main to more effective “triaging” of these contacts, ensuring that only work was accepted that corresponded to the continuum of need (Pan London Thresholds) adopted by the LSCB and its partner agencies in September 2012.

During the year, the number of core assessments increased and the number of initial assessments decreased, in line with a more holistic approach to intervention and assessment, which focused on resolving family issues rather than undue concentration on the timescales for assessments.

The number of children on Child Protection Plans continued to stabilise during 2012-2013. As at 31st March 2013 there were 213 children subject to a Child Protection Plan compared to 346 in the previous year. During the course of the year, 206 children became subject to CP Plans, whilst 383 children were removed from CP Plans. This is an indication of effective intervention, with risks being ameliorated, and a more consistent “step-down” into Universal and targeted services. As a further indicator of better outcomes being achieved during the year, only 26 children became subject to a child Protection Plan for a second or subsequent time, compared to 46 in the previous year.

The timeliness of core assessments was affected by the increased volume in the number of them being completed (1,285 compared to 1,025 in the previous year). However, this was in the context of major transformation during the year, moving from initial and core assessments to the single holistic assessment (45 days) reflected in the New Guidance – Working Together 2013 – which was published in March 2013. Overall, despite a year of significant transformational change in Children’s Social Care, the Key Performance Indicators reflected in the CIN Census, show a positive picture of practice and improved outcomes for children within the Child Protection System.

Lynda Crellin
Independent Chairman
November 2013

2. WHAT WE HAVE DONE

What we planned to do – our key priorities

A new business Plan for 2011-14 was agreed by the LSCB in spring 2011. Five priority areas were agreed, based on analysis of current information and trends, along with key Government agendas

The five priority areas of work are detailed below, with a summary of work completed against those priorities during 2012-13.

What we planned to do at beginning of 2012-13	What we did
Priority 1 Improve LSCB functioning	
Continue to implement Munro recommendations and Government requirements as required, particularly updated Working Together and related guidance.	We responded to the consultation on the new Working Together and the chair, with other independent chairs, met with representatives from the DfE to discuss concerns. We were represented on the London editorial board responsible for updating the London procedures.
Carry out a section 11 audit across agencies.	Audit carried out in late 2012. Findings reported to March Board.
Fully develop and implement the Quality assurance framework.	QA framework agreed and appointment of Audits manager resulted in more case information available to the Board this year.
Rationalise the performance information produced by social care and the Children's Trust, and feed into improved data framework for the LSCB.	By year end a more detailed analysis of performance information was available to the Board.
Incorporate views of children, young people and their families in the work of the LSCB through response to Borough survey, views of those on cp plans.	System put in place to obtain views of children going off CP plans.
Incorporate the views of staff in the work of the LSCB though responses at stakeholder day and questionnaire.	Stakeholder day held with staff and their views were incorporated into business planning. Newsletter deferred to 2013-14.
Appoint lay members to the Board.	Two lay members were appointed and are now included in Board and sub group membership.
Improve engagement with GPs and Clinical Commissioning group.	CCG representatives agreed and began attending Board March 2013.

Priority 2 Assess and improve operational practice	
Ensure all agencies fully understand the social care threshold criteria, and that it is embedded in the development of preventative services.	Use of new threshold document (based on London levels of need) agreed. Early help family assessment developed, agreed to replace CAF and piloted. Single assessment developed for social care.
Improve the oversight of single agency audits.	Done via audit form submitted in summer 2012 and section 11 audit in winter 2012/13.
Develop and learn from a multi-agency quality audit programme for the LSCB.	Case audit carried out using peer review methodology. Multi-agency work also assessed as part of social care audits reported to Scrutiny Committee.
Roll out the schools safeguarding clusters across whole Borough.	Two clusters in place by year end and working effectively. The final third cluster planned for 2013.
Priority 3 Improve outcomes for children affected by key risk issues	
Improve the identification and support for children and young people involved in sexual exploitation.	This work was incorporated in the existing operational sub group. Strategy developed and incorporated in that for missing/trafficked children. Staff from Japan and Norway visited to view Hillingdon exemplar practice at Heathrow Airport.
Improve the identification and support for children and young people involved in gang activity.	Training delivered in schools on this topic.
Improve quality of information sharing and risk assessments for children and young people who go missing, particularly looked after children.	Services for children missing from care reviewed and reported to Council scrutiny committee. Recommendations overseen by LSCB.
Continue to try and benefit from funding opportunities for children and young people affected by domestic violence.	Some short term funding provided therapeutic support for children identified through the local refuge.
Improve the effectiveness of joint working across children's and adult services in respect of mental health and substance misuse issues.	Joint protocol between children's social care/adult mental health reviewed and refreshed. Joint sessions delivered across teams. Specialist post appointed in children's social care.

Raise awareness of child abuse linked to faith or belief.	Links made with a total of six mosques and madrasahs. Training to be carried out in 2013-14.
<u>Priority 4</u> Ensure a safe workforce	
Carry out and respond to audit of single agency training.	Training census carried out December 2012. Several agencies responded but some agencies were unable to supply relevant data. Once the data is provided, the results can be analysed and reported to the Board with an action plan for improvement.
Develop ways of assessing access to and impact of training.	Introduced the NSPCC's *Connect, Share & Learn* tool to evaluate the impact of training. This is a scenario based tool that evaluate how able staff are to respond correctly to certain safeguarding situations. Changes to statutory guidance, however, require the tool to be updated.
Enhance support to front line managers. Look at more creative ways to improve access to and attendance at multi-agency training.	Action Learning events have been created for first line managers, named and designated staff to provide bespoke and in depth learning for managers.
Continue to improve responses to allegations against staff.	Increasing numbers of allegations responded to and managed appropriately, including historical following Savile revelations. Guidance and procedures on managing allegations rolled out to all schools.
Ensure compliance with new legislation and guidance around recruitment.	The Disclosure and Barring Service (DBS) has merged functions of the Criminal Records Bureau and the Independent Safeguarding Authority. The HR Sub Group has worked with partner agencies to ensure that recruitment practices maintain safeguards for recruiting suitable staff into the children's workforce. Full multi-agency training programme delivered to 2398 staff across agencies

Priority 5 Learn from Case Reviews	
Implement learning from management reviews.	Five cases considered by SCR sub group and 1 became subject of a formal management review with recommendations reported to LSCB.
Complete implementation of the actions arising from the SCIE pilot.	All actions completed, including establishment of Risk Panel to review stuck and contentious cases.
Continue to implement learning from unexpected child deaths and disseminate key messages to local professionals.	Local and national messages disseminated quickly though hospitals and early years networks –particularly in respect of safe sleeping arrangements for babies.

3. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

Operation

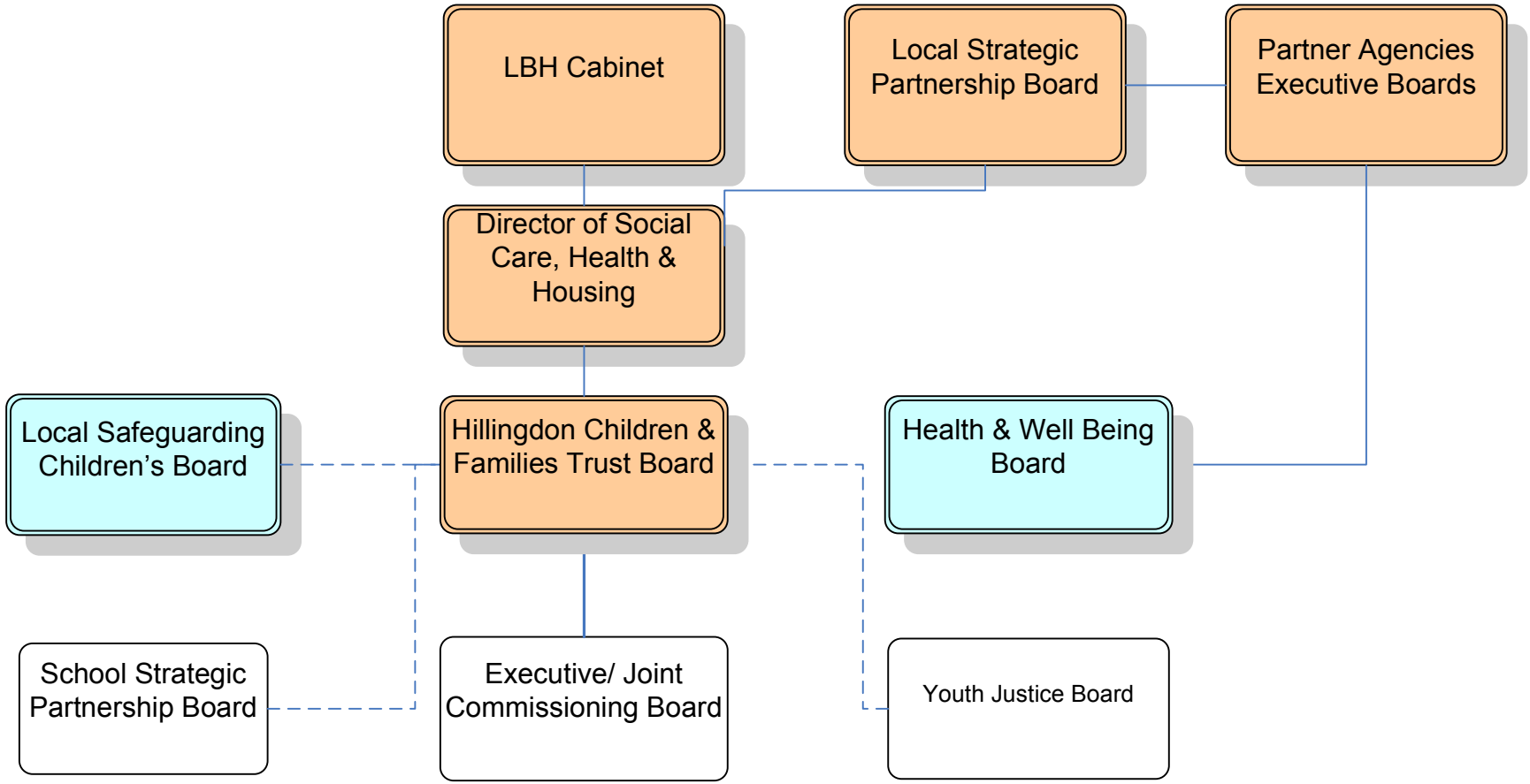
The LSCB operated during 2012-13 in accordance with Working Together 2010, updated in early 2013. Current local governance arrangements are identified below. There are currently 11 sub groups who meet between Board meetings and take responsibility for actions identified in the Business Plan. The Domestic 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 between meetings 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.

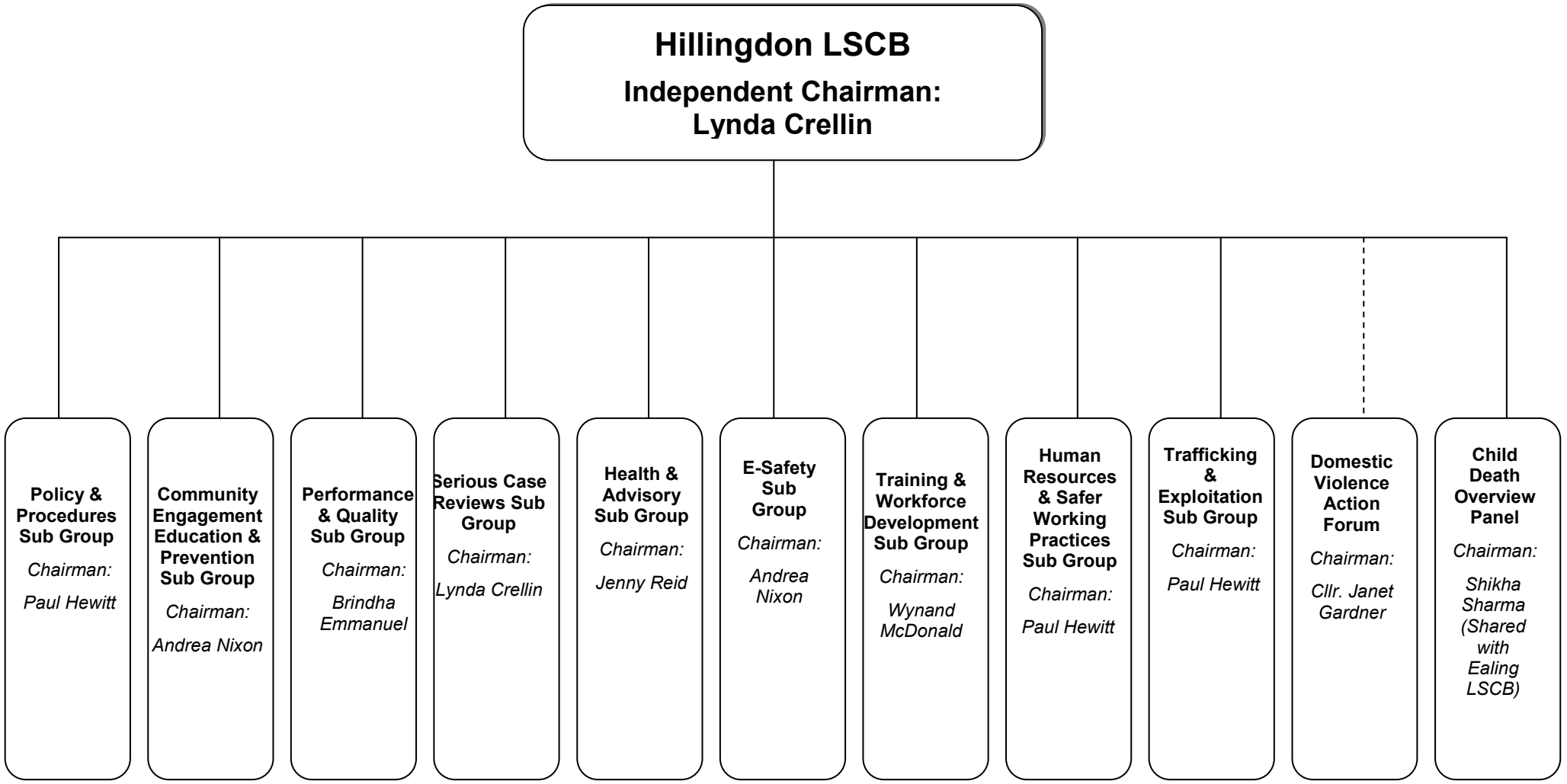
This annual report will be presented to Council Scrutiny Committee, to Cabinet and to the Health and Wellbeing Board. It will feed into the Local Strategic Partnership Board (LSP) through the HCFTB. Future arrangements may evolve further in accordance with the Munro review which recommends that the LSCB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

Closer links were made with the Safer Adults Partnership Board (SAPB) and, from November 2011, both Boards meet on the same day, and are chaired by the independent chairman. Each Board has been able to keep its separate identity, but we have used the opportunity to use the cross over time between Boards to look at items of joint interest. These have included domestic violence, and the development of preventative services for families.



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 2012-13 was 60%, which is 16% less than last year. 100% attendees were CAIT, the Voluntary Sector, Hillingdon Community Health, NHS Hillingdon, Hillingdon Hospital, Children's Social Care and Adult Social Care. Council Education had 75% attendance and Public Health and YOS showed 50%. From schools we lost the SEN representative but primary heads had 100% representation and secondary 25% due to the departure of the lead head teacher during the year. Borough Police, Probation and Border & Immigration managed to send limited representation throughout the year due to structural changes within each of these agencies. This reflects to a certain extent changes and flux within those organisations. 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. Membership was reviewed during the year to ensure the right level of senior representation across agencies. A list of members is attached at appendix 1.

In the latter part of the year the LSCB appointed two lay members who took up their role in early 2013 and have attended Board meetings since June.

The Clinical Commissioning Group (CCG) began its work formally in April 2013, having operated in shadow form during 2012-13. The CCG is represented on the LSCB by the lead GP and the Executive Lead for children. The relationship between the LSCB and GPs as providers remains work in progress.

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. Thus the systems are already in place to meet the new requirements in Working Together 2013 which places accountability for the LSCB chair with the Local Authority Chief Executive.

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.

Section 11 audit

The LSCB has a legal duty to ensure that statutory partners comply with section 11(1) of the Children Act 2004. During 2012-13 the LSCB undertook an audit asking agencies to demonstrate that they are compliant with their section 11 duties. The LSCB sent out a self assessment tool to all LSCB partners, using the tool developed by the London Safeguarding Board. All

relevant statutory agencies responded and also some non statutory voluntary bodies. Agencies were asked to evaluate themselves against eight agreed standards issued in guidance by the Secretary of State. Partners were asked to provide evidence to support their evaluation and the completed audits were evaluated by the Performance and Quality sub group.

Overall, agencies in Hillingdon were able to demonstrate a strong commitment to safeguarding throughout their organisations backed up by governance structures, lines of accountability, policies and procedures, recruitment processes and training. In some organisations, particularly the newly established Clinical Commissioning Group (CCG), governance structures were being reviewed and tightened up. The most significant area for development across all partner agencies was in relation to the standard that focuses on the incorporation of the views of children and young people in service development. This has been incorporated in LSCB planning.

Another area for development was the monitoring of commissioned services.

Of particular note in this audit was the enthusiastic participation of non statutory agencies who work with children. Interestingly, these agencies were more likely to comply with the standard about taking children's views into account

Following the audit, the chair met with senior managers in some key agencies to test out evidence and identify areas for improvement.

A report on the audit was presented to LSCB in March 2013 and appropriate actions agreed, particularly in respect of the involvement of children and young people.

Hillingdon Council

The Council was represented on the LSCB by the Director of Social Care Health 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 children missing from care and social care audit report. Recommendations are incorporated as appropriate in the LSCB work plan. This annual report will be presented to Scrutiny Committee and Cabinet.

Internal Governance arrangements

The statutory Director of Children's Services has maintained oversight of key services relating to safeguarding children, via a monthly meeting with the Lead Member of the Council for Children's Services, and the Chief Executive. This monthly mechanism of regular reporting has enabled the prioritisation of child protection work, and allied safeguarding issues to be constantly reviewed, in the light of local circumstances. The monthly review includes a performance scorecard which enables the Chief Executive, Lead Member and

Director of Children's Services to have scrutiny of child protection activity on the ground.

Allied to this monthly meeting, there is a six monthly report made to the Corporate Management Team (CMT) across directorates within the Council. This report is also presented to the Policy Overview Committee (POC) to ensure oversight of children safeguarding performance within the Council.

Running alongside the performance scorecard has been a quality audit programme, which has also helped to strengthen safeguarding and highlight areas for improvement. The findings from these audits are reported to POC on a quarterly basis.

One of the key issues for improving and strengthening child protection practice is the quality of management oversight and supervision provided to front line social workers. This was a significant theme in the audits carried out within Children's Social Care during 2012-2013.

In order to address this issue, a one year programme of Reflective Supervision was delivered to all managers in Children's Social Care (including Residential Managers) during 2012-2013, by an expert from the Tavistock Clinic. This was regarded as a significant achievement by managers and was welcomed by the front line social workers, as shown in a survey after the Reflective Supervision.

Running alongside this programme was a plan to refresh and re-launch the Supervision Policy, with greater emphasis on the use of supervision contracts/agreements, to ensure that case discussions are properly recorded, and take account of researched and informed practice. The Supervision Policy was re-launched by the Deputy Director in February 2013. Future audits will be monitoring the implementation of the policy, with specific reference to a Supervision Contract being in place, as the foundation for Reflective Practice.

During the year 2012-2013, a Designated Principal Child & Family Social Worker was nominated within Children's Social Care, as a way of ensuring that social workers' views would be represented at a senior level. The Designated Principal Social Worker is also the head of Children Safeguarding and Quality Assurance, and meets monthly with the Chief Executive and Lead Member for Children to represent social workers' performance, pressures and achievements. This has helped to ensure that front line services are protected within the inevitable spending reductions which have affected the Local Authority.

Youth Offending Service

Achievements

All staff undertook training on assessments, resulting in an improvement in quality from 69% 84% of documents being assessed as satisfactory or above. 78% were identified as good.

The management team developed a further training exercise to improve specifically in the assessment areas of risk and vulnerability. As a result:

- The percentage of risk of harm assessments identified as good rose from 25% in August 2012 to 67% in February 2013;

- The percentage of vulnerability assessments identified as good rose from 38% in August 2012 to 67% in February 2013.

The Integrated Intervention Plan template designed to combine the activities addressing risk of harm, offending and vulnerability into one holistic plan was further revised in 12-13 to include sections on learning style, diversity and victim safety.

A practice workshop on the planning process resulting in an improvement in plan quality from 92% to 100% being identified as satisfactory by November 2012

The YOS has developed a number of new intervention programmes for both young people and parents this year including:

- A revised knife crime programme for young people;
- A bespoke programme for parents with sessions on substance misuse, knife crime and gang activity;
- One billion rising programme for young people focused on domestic violence and developing healthy relationships.

The YOS has representatives at two forums focused on gangs and associated links to exploitation one run by West London YOTS and the other by the Youth Justice Board.

In terms of outcome data:

- The number of fist time entrants into the criminal justice system continued to fall with 156 recorded in 12/13 compared to 212 in 2011/12.
- 37.5% of young people sentenced between April 2010 and March 2011 committed further offences an increase of 0.4% against the previous period. This is lower than for the London region (39.8%) but higher than for England (35.8%). The number of further offences committed by those young people was lower than both the national and London Averages.

Challenges in 2012-13

The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) introduced a number of significant changes to the youth justice system which required a revision of existing YOS practice during 2012-13. The most significant changes were the introduction of:

- The remand to Youth Detention Accommodation, replacing the existing secure remand framework
- Looked after status for all young people remanded into youth detention accommodation.

Education

Overview

Safeguarding of children in Hillingdon early years centres and schools appears to be secure.

The structures for identifying children at risk are robust and include all schools and centres irrespective of their status: Community, Academy, Faith, Free or Independent. Regular training takes place for staff and governors; monthly briefings of officers take place with the CEO. Data is gathered systematically and analysed. The conclusions are used to inform professional practice. Where a child may be at risk there is audit evidence of prompt intervention with robust follow-up work. The work of safeguarding in education sits securely within the overall structures and processes of Children and Young People's Services.

Policy is regularly reviewed, practice is monitored and data is used to inform training and development work.

Children without a school place

A recent POC review identified some concern with schools 'off rolling' pupils, these actions are not always known to the Local Authority; therefore some vulnerable children are without a school place. Where possible they will be identified by the school's education welfare officer although there are some risks following the change in their role from September 2013.

A new provision for young people without a school place has been formally established from September 2013 following the above mentioned POC review recommendation. Hillingdon Tuition centre has responsibility for the provision and will work closely with the admissions team to offer an interim placement until a school place is secured.

The Behaviour Support team has been transferred to the Hillingdon Tuition centre management and will continue to work to the schools Service Level Agreement. There is some risk to the capacity of the team to carry out LA roles in the future.

Elective Home Education

The Elective Home Education role will be embedded within the new education structure in response to the Council's statutory role including that of safeguarding for these children and young people.

Safeguarding in schools

Safeguarding in schools in Hillingdon remains a high priority. Schools continue to access training, advice and support through the Child Protection Lead for Education. The relationship between schools and Social Care has been strengthened through the development of the Schools Safeguarding Clusters. These clusters are made up of designated teachers from primary and secondary schools and chaired by a Team Manager from Social Care. Each cluster meets termly and schools have found this discussion forum invaluable.

The Local Authority Designated Officer has been part funded through schools, which demonstrates their commitment to ensuring that pupils remain safe. This is a growing area of work, in which the LADO provides advice to schools and oversees investigations into allegations made against professionals. A monthly report is submitted to the Principal Social Worker, outlining progress and outcomes from allegations. A report is also submitted to the Local

Safeguarding Board on a quarterly basis, outlining the number of reported incidents.

The possible challenges going forward are to ensure that safeguarding responsibilities within the growing number of academies remain a high priority and our current relationship with academies remains strong.

Early Intervention Services

Main achievements 2012 - 2013

The Council's Children's Pathway Transformation process, and its associated discovery and design work, have resulted in the closer alignment of services concerned with intervening early to prevent family problems developing or escalating. This has resulted in the bringing together of a number of service areas including, local authority managed Early Years and Childcare provision, the Children's Centre programme, youth work and youth support services including, sexual health, substance misuse, counselling and support, information advice and guidance services, Youth Offending and Family Key-working Services, the Troubled Families Initiative and related programmes ranging from parenting to training programmes. A new strategic direction for these services is being developed in collaboration with partners. An Early Intervention and Prevention Strategy has been developed with the mission to:

> "Develop an integrated model for the provision of early intervention and prevention so that services may intervene early and as soon as possible to prevent or tackle problems emerging for children, young people and their families or with a population most at risk of developing problems".

Work continues to mobilise services and partners in order to realise this mission with an Early Intervention and Prevention Strategy Group established as the partnership vehicle for doing so. The focus of this group is to embed a comprehensive and integrated system for the provision of early help to families in Hillingdon. The group also oversees the development and implementation of the Strategy which includes the following key operational objectives:

- Securing an integrated preventative 'Local Offer' including early help services with the capacity and flexibility to response to locally defined need;
- Developing mechanisms for communicating the offer to children, young people and families and enabling their access to services;
- Developing and embedding early help principles and processes which enables practitioners to consistently assess and respond to whole family need in a straight forward and timely manner; and
- Secure teams of key-workers who work in collaboration with those providing the Local Offer so that their clients may receive the support and interventions they need.

To date the local offer of tier 1 and 2 provision has been mapped. A locality-based method for developing and co-ordinating the offer, the Family Centred Network, has also been developed and is being tested in the south of the Borough with a view to being rolled out across Hillingdon.

A new Family Key-working Service has also been developed. The Service is testing new ways of working concerned with providing families with different levels of need 1-1 support to overcome problems and develop resilience to avoid future difficulties

A new early help assessment tool and early help 'team around the family' process has also been developed and is in the process of being tested and rolled out.

Over the next year and beyond work will continue to develop and implement the Early Intervention and Prevention Strategy with partners with a view to strengthening our collective approach to providing families with the early help they need to avoid or overcome problems that lead to poor outcomes.

Early Years Services

The Early Years Service supports the development of quality, alongside the development of the workforce, across all sectors of early years provision. This includes developing the quality of experiences for all children attending registered provision, the quality learning and development experiences and those for children with Special Educational Needs and Disabilities (SEND).

Within the service there is a team dedicated to monitoring the compliance of settings in relation to the legal requirements for safeguarding outlined within the Statutory Framework for the Early Years Foundation Stage. The challenge for all teams within the Early Years Service is to engage private businesses in developing the quality of their provision and to ensure good practice is embedded in every day practice.

Main achievements in 2012-13

Over the last year the focus of the work has been to develop those settings that were not meeting the legal requirements for the safeguarding of children. The impact of their work can clearly be seen below.

Quality of safeguarding and well being of young children in settings:

- Overall quality – improved quality in settings that were not meeting the legal requirements (in 2011-12) by 22%. There are now 23% more settings working well in excess of the minimum quality standards.
- Quality of safeguarding – 51% of settings were not meeting the legal requirements in 2011-12. This has now dropped to only 8%. 19% more settings are working well in excess of the minimum quality standards.
- Suitable people – 34% of settings were not meeting the legal requirements in 2011-12; this has now dropped to 6% and there are now 25% more settings are working well in excess of the minimum quality standards.

Developing the workforce in relation to Safeguarding and children's well-being:

- 333 practitioners have accessed safeguarding training this year. This has included setting practitioners and childminders and has been delivered via central and in-setting training events.

- Almost 600 practitioners have accessed supervision training over the last year to improve the structure of supervision sessions to include safeguarding as a standing agenda item

Schools

Schools safeguarding audit

Following the Serious Case Review in 2010-11, a bi-annual review of schools safeguarding activity was agreed. In 2011 therefore The Safeguarding Board carried out an audit of the safeguarding roles and procedures within schools in Hillingdon. This audit is completed bi-annually and we have had a previous 100% return rate which demonstrates the commitment that Hillingdon schools have to ensuring that pupils remain protected. The audit is completed by primary and secondary schools including all Academies.

The audit also highlights gaps in provision in which the Board are then able to offer support and guidance. From the previous audit it was clear that not all schools had a key holder policy as recommended in the serious case review. In working with a Hillingdon High school a model policy was developed and circulated to all schools.

The audit has been repeated in summer 2013 and the results will be reported in due course.

Schools Safeguarding cluster meetings

The school safeguarding cluster meetings were established during the year and have gone from strength to strength. We currently have two clusters, a North cluster and a South cluster, that are very well attended. In September we hope to launch a central cluster also chaired by a Team Manager from social care. The meetings are held termly and attended by both primary and secondary schools including Academies. New policies, procedures and changes to working practice within Hillingdon are discussed and schools identify topics that they would like to raise. The second half of the meeting focuses on specific cases to either understand why decisions were made or to raise concerns that need to be addressed by other agencies.

The feedback from the cluster meetings has been very positive from schools and social care. It has improved the understanding of each others roles and opened communication between the services.

Voluntary Sector

The voluntary sector in Hillingdon is made up of around 100 independent organisations working with children, young people and/or families. They range from branches of large national charities to small local groups which may provide services to just a handful of children. Approximately 75% are volunteer led with no paid staff. The other 25% do have paid staff. Services provided also vary and include fun or play activities, services for the disabled, learning opportunities, sport, advice, support and guidance in a range of areas, counselling and diversion from crime. This list is not exhaustive.

Unlike the other agencies represented at the LSCB, the diversity and independence of the sector makes it difficult to generalise about

arrangements for safeguarding in the sector. There are as many different arrangements as there are organisations.

Branches of national charities usually have their own safeguarding advisors and training officers with robust arrangements for ensuring policies and practice are adhered to. Smaller voluntary agencies use a range of organisations for support and training. These include the NSPCC, Churches Child Protection Advisory Service (CCPAS) and Safe Network. The LSCB ensure that a local support service is also available for voluntary agencies delivering services in Hillingdon. That support service ensures that:

- Voluntary Agencies are represented on the LSCB, currently by Hillingdon Association of Voluntary Services (HAVS)
- Feedback from the LSCB, such as changes in policy and practice, is circulated to all voluntary agencies
- Voluntary agencies are able to access LSCB training
- Where voluntary agencies don't have their own arrangements for introductory training, they can attend training delivered by HAVS or the HAVS representative will deliver training 'in house'
- Voluntary agencies have support when they need it, to write and develop policies and good practice
- Voluntary agencies have someone they can speak to if there is anything they are unsure of regarding safeguarding.

This support is provided by HAVS.

In the past year, HAVS has delivered more introductory training than ever before with 6 courses delivered to 103 people in total, showing that the sector has a genuine desire to engage in the safeguarding agenda. Voluntary agencies also responded positively to LSCB processes such as the Section 11 audit and trialling of the new shared assessment process. Voluntary agencies have continued to be updated with developments such as the introduction of the 2013 version of Working Together.

Health Agencies

All the main health agencies are represented on the LSCB, including the joint Director of Public Health (DPH) who is the executive safeguarding lead, the designated doctor and designated nurse. The Designated Nurse was during this year based within the Public Health Department and, alongside the Designated Doctor, has the main responsibility for overseeing safeguarding practice in each health agency, including the Hillingdon Hospital and Harefield and Brompton Hospital Trusts. The designated professionals reported directly to the DPH. From April 2013, they report to the CCG

Each of the main Provider organisations has its own safeguarding steering group which feeds into NHS Hillingdon Safeguarding Committee. Some of the quality assurance work and monitoring of key actions rest with the health sub group of the LSCB. However, the overarching statutory duty (including quality assurance) to ensure that safeguarding and promoting the welfare of children is discharged effectively, rests with Hillingdon PCT and, from April 2013, the

successor NHS commissioning organisation, NHS Hillingdon Clinical Commissioning Group.

Central and North West London Health (Mental Health services)

Main Achievements 2012/13:

- **Establishing shared supervision arrangements**: Addiction Services have agreed times when safeguarding children cases can be presented to CSC workers for support and challenge.
- **Young Carers**: The CNWL Safeguarding Children's Advisor has worked with local partners to develop a training package for staff to raise awareness of young carers issues. CNWL has also established a Focus Group for Young Carers so that they can feedback their views on services and what improvements would make a difference to them. Hillingdon Young Carers have been present in this group.
- **Section 11 Audit**: The Trust completed a Section 11 Audit for Hillingdon and an evidence file documenting the supporting evidence of compliance was made available. Where further work was needed an action plan was developed and these actions have all been completed.
- **Supervision Audit across adult and CAMHS** – carried out by external auditors. This found all staff had been supervised with their CP cases in the previous month. The main learning point was the need to record the safeguarding children supervision on the electronic record, and to update the Supervision Policy so guidance was clear on this. **Safeguarding Helpline Audit**- showed that service in Hillingdon used this on a regular basis and there was a high level of awareness amongst staff on how to access support on safeguarding issues.
- **Attendance at safeguarding training including refresher training** – presently CNWL level of attendance on training is above 85% and the Trust is fully compliant with the David Nicholson DH requirements on this. CAMHS and staff who regularly see children received training on the CAF.

Main Challenges

We have identified some key challenges for the Trust in 2012/13:

- **Reviewing CAMHS**: Commissioners have been working with CAMHS to review the service and concerns remain within CAMHS about the level of funding and capacity to meet local needs. A Royal College of Psychiatrists review identified some areas to strengthen also potential gaps in commissioning.
- **The financial environment** and the impact on contracts with CNWL may mean that services have to reduce and may not meet the needs of children, the demand of families or the expectations of partner agencies.
- **Impact of the benefit changes** on families may result in moves of families where there are concerns and disrupt treatment packages, or risk being lost to the systems in new areas. The areas where families

may move from to Hillingdon are likely to be managed by CNWL, so this risk is mitigated.

- **Establishing information systems to gather the information needed**, that is, to collect more outcome focused measures and qualitative data to assess the effectiveness of services, including linking adults and children in the IT system. Many of the IT systems do not currently support the collection of such information.

Hillingdon Community Health, (HCH)

CNWL NHS Foundation Trust is one of the largest trusts in the UK, caring for people with a wide range of physical and mental health needs. It provides healthcare to a third of London, Milton Keynes and parts of Kent, Surrey and Hampshire. Within the borough of Hillingdon, CNWL provides both mental health and community care services (the latter is known as Hillingdon Community Health).

In relation to the community services provided in Hillingdon by CNWL, the following key areas are of note:

Governance arrangements in respect of Safeguarding Children

The Hillingdon Community Safeguarding Children Team consists of a Named Doctor, two Named Nurses, a Paediatric Liaison Health Visitor post and 2 part time administrators.

In 2012, Hillingdon Community Health was able to declare full compliance with safeguarding responsibilities as outlined in Outcome 7 of the Care Quality Commission's Essential Standards of Quality and Safety.

The community division holds a quarterly safeguarding meeting, chaired by the Managing Director for Community Services, to review policies, results of audits, training plans, lessons learnt from safeguarding alerts as well as agreeing and overseeing the annual work plan.

Representatives from the community division also attend the Trust's Quarterly Safeguarding Committee which is chaired by the Board Level Safeguarding Lead - Executive Director of Operations and Partnerships.

As a key borough partner, there is Director level representation from the community division on the Hillingdon LSCB with representation also on each of the sub groups which support the LSCB.

Outcomes for Children

In line with the concepts outlined in "Improving local safeguarding outcomes,"[1] the safeguarding team commenced work to focus on assessing outcomes for children with a particular emphasis on outcomes such as "before and after" discussions. An audit process was established whereby health visitors and school nurses were asked to compare the family's position at the commencement of a child protection plan, then at a midway and again closing

[1] "Improving local safeguarding outcomes: Developing a strategic quality assurance framework to safeguard children" (2011) Local government Group/ London Safeguarding Children Board

point. The intention was to identify what impact the intervention has had on the child's life.

This audit was undertaken in 2012 and the results were encouraging. Of the 7 practitioners interviewed, 6 felt that the child protection intervention had improved the outcome for the child/ young person in their service. A health visitor discussed a long term child protection plan for neglect. There were some improvements with a move to a different property but these improvements could not be sustained and the health visitor has concluded that the child protection plan cannot safeguard the children and the only option is moving the case to the legal framework. The other six cases demonstrated some effective multi-agency working and good communication within the core group. These outcomes will be discussed with health visitors and school nurses in supervision and in their local professional forums.

Audits

A number of audits were conducted during 2012-2013 as outlined below:

1. Child Protection Record Keeping- 2 audits in 2012-2013. The results in 2013 showed a significant improvement. There will be some ongoing work with children's services staff as an area of continued weakness is eliciting and recording the views of the child.
2. Evaluation of level 2 training. We surveyed 50 clinical staff and 28 responded. Encouragingly, 100% of respondents felt it was appropriate to their role. This included those who see adult clients only. 99% of respondents knew who to contact if they had child protection concerns and 99% believed they knew what to do if they needed to safeguard a child.
3. Evaluation of Safeguarding Supervision. Although there was a poor response to the online survey it was generally positive as nearly all the respondents stated they were receiving safeguarding supervision in a timely manner, a large majority found it promoted reflective practice and most considered it reduced work based stress.
4. Review of Information Sharing Processes in A&E. Key points being addressed with Hillingdon Hospital are around the lack of photocopies of attendances resulting in transfer of poor quality information to community staff and incomplete or blank GP discharge summaries. A new method of sending GP discharge summaries has commenced.
5. Child Protection medical examinations. Actions for the community paediatricians include:
    - Ensuring that the Team Manager number is included in initial referrals
    - Reducing the time between receiving referral and Paediatrician calling Social Worker
    - Encouraging the social worker to make referrals earlier in the day

Additional audits within HCH relevant to safeguarding children:

6. The domestic violence specialist health visitor audited the domestic violence traffic light system for police reports.
7. The children's services teams audited the safeguarding children processes action plan.

Training

Training continues to be a high priority and all training complies with the guidelines set out in the intercollegiate document (2010). Overall compliance rates remain good across the community teams as follows:

- Level 1 - 95%
- Level 2 - administrative staff - 92%
- Level 2 - clinical staff - 80%
- Level 2 - for HV and SN's - 89%
- Level 3 - Working Together Multi-Agency - 87%
- Level 3 - Child Protection Process Single Agency - 87%
- Level 4 – Named Professionals – 100%

The Community Division Named Nurses co-facilitate the level 3 multi-agency Working Together course.

Supervision

The Safeguarding Children Team continues to oversee and provide support in relation to the delivery of child protection supervision to all relevant staff groups in the community.

Risk management

The CNWL Community Services Named Nurse chairs this multi-agency risk management forum which was established by the LSCB. The Terms of Reference were revised in 2012 and the panel now provide opportunities for key partner agencies within safeguarding to review their responses to high risk cases. In addition we hope to learn from the experiences of practitioners in cases where risk is being jointly managed by the professionals. It is intended that this group will use reflective practice and learning to help to drive up standards in practice and disseminate the learning across the partnership within the Local Safeguarding Children Board. The group remains responsible for Escalation and Conflict Resolution.

The Hillingdon Hospitals NHS Foundation Trust

Safeguarding children arrangements at the hospitals have continued to strengthen during 2012/13. 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 is now reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2012. The hospitals are well represented on the LSCB and its sub groups by the hospitals named professionals for safeguarding and senior management staff.

The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. This replaces the Safeguarding Children Steering Group (SCSG).The Committee is chaired by the Executive Director of the Patient Experience and Nursing.

Domestic violence awareness continues to be raised across the organisation with a training session delivered by HESTIA. The Trust 'Safeguarding Matters' newsletter for adults and children is sent to staff on a regular basis.

There is continued support in the development of the safeguarding midwife role. This will be strengthened by the new community team leaders being trained to provide clinical supervision of cases. This follows a community midwife reconfiguration in April 2013.

A Practice Development Nurse for Paediatrics is now in post (working primarily in Paediatrics), and an Emergency Nurse Practitioner (ENP) post has been advertised. A band 5 children's nurse is to start in June

Key Trust staff have been actively involved with the evaluation of the new Interagency Form for Child protection .The Trust has also undertaken a Section 11 Audit.

Key challenges moving forward in 2013/14 include:

- Ongoing difficulty in recruiting more paediatric nurses to the paediatric Accident and Emergency (A&E) department. Currently there is a Senior Staff Nurse and Sister dedicated to lead on the work within the paediatric A & E. This is currently on the Trust Risk Register with regard to actions that are being taken forward to mitigate any risk; this is reviewed at the Trust Safeguarding Committee.
- The achievement of >80% compliance with safeguarding children refresher training, particularly in light of revised intercollegiate guidance and the need for more staff to undertake further training.
- Ensuring high quality safeguarding practice amidst financial savings across all partner agencies, embracing the Department of Health's QIPP (Quality, Innovation, Prevention and Productivity) work-stream with regard to doings things differently to ensure the quality of care is maintained, despite cost improvement programmes.

An annual work programme has been developed to ensure priorities for 2013/14 are closely monitored and required actions progressed. The Trust is keen to work with partner agencies to ensure that information on patient outcomes in relation to safeguarding is captured to support further improvement work.

Metropolitan Police

Child Abuse investigation team (CAIT)

- The MPS has again continued to deliver a commitment to providing regular training on safeguarding, child protection and effective leadership for managers and practitioners across frontline services. The MPS provision of Multi-Agency Critical Incident Exercise (MACIE) training for each London borough has been completed and SC&O5 will work to ensure that the financial commitment (currently fully funded by the MPS) to MACIE training is maintained.
- The Specialist Joint Child Abuse Investigation Course (SJCAIC) which is a two week training course for new staff members run jointly with social workers. SC&O5 continue to run and induction week for new staff that they attend on their first day of joining the command. This course is one week and the aim is to provide basic initial understanding of the Child Protection world and partnership working.

- SC&O5 is currently in the process of preparing an 'Advanced child interview course' for very young children and children with learning or communication difficulties. This will deliver a better service to victims and witnesses of abuse and will contribute to wider efforts to enhance community confidence in the police.
- Over the last 12 months, SCD5 has continued to utilise the Child Risk Assessment Matrix (CRAM) across London to better inform decision-making. This process makes a qualitative assessment of all relevant factors relating to a child and allows appropriate and informed decision-making, and is now more comprehensively recorded on the police crime reporting data base. A thematic review of this system is intended for 2013/14 to identify any learning and further enhancements that can be made.
- Responsibility for ensuring compliance and pan London governance of CAITs sits with the SCD5 Continuous Improvement Team (CIT). The CIT includes quality assurance, training and partnership. SC&O 5 have merged with SC&O2 (Rape) Command as of 1/6/2013. The quality assurance functions and staff will be merged together to provide better resilience and capacity to develop inspection programmes, performance monitoring and identification of trends / themes and any relevant learning.
- The Command has reviewed the Specialist Child Abuse Investigators Development Programme (SCAIDP) in line with the new learning descriptors produced by the NPIA. The command is now developing the "continuing professional development" aspect to ensure that all accredited investigators maintain this qualification through evidence based assessments.
- SC&O5 has reviewed its response to Victim Care in line with the Commissioners Total Victim care ethos. The Command has reviewed systems to ensure that victims or a suitable point of contact are being updated regularly. Performance in this are is subject of monthly SMT review and during team inspections. It is recognised that the command can continue to improve in this area.
- SC&O5 works closely with local boroughs who lead on community (including youth) engagement. SC&O5 also has a dedicated partnership team, which leads on developing engagement with the communities we serve. The partnership team undertake a number of strands of work around key areas to enhance engagement and encourage community confidence .Examples include engaging with other professionals such as, LSCBs, Health, Education, Probation, LADOs to promote child protection procedures and provide safeguarding awareness. The Manual of guidance on spirit possession is being widely adapted and used. Pro-active community engagement events around issues such as spirit possession and FGM have been well received. The use of SPOCs on each CAIT to offer support and guidance in relation to spirit possession and FGM is ongoing and will ultimately promote the use of Non Government Organisations to engage with children and families. Engaging SNTs with LSCBs to

participate in safeguarding inputs to religious communities is in its early stages. Sudden Unexplained Infant Death (SUDI) training is provided for all relevant police personnel and associated professionals. This training includes work with families who have suffered bereavement. SC&O5 staff attend and also contribute to LSCB training and promotional events.

- SC&O5 has reviewed its response to Victim Care in line with the Commissioners Total Victim care ethos. The Command has reviewed systems to ensure that victims or a suitable point of contact are being updated regularly. Performance in this are is subject of monthly SMT review and during team inspections. It is recognised that the command can continue to improve in this area.
- The SMT has recently introduced a daily 'Grip and Pace' meeting which reviews all overnight issues including SUDIs and children on a CP plan being victims of new allegations. This ensures that enhanced protection for children subject to a child protection plan is reviewed by SMT, actions identified and prioritised. NVOC are recorded centrally by the Continuous Improvement team.
- Project Topaz has been implemented to work with partner agencies to safeguard and protect children who are subject to a child protection plan. Referrals staff are required to identify every occasion a child subject to a CPP becomes the subject of a new allegation. The Continuous improvement team review these incidents and Include them in the SC&O5 Daily and 'Grip and Pace' meeting.
- SC&O5's relationship with MASH is being reviewed under the direction of an SMT lead. Mash has been rolled out across 10 London boroughs and by 2014 will be across all 32 boroughs.
- SCD5 have invested significant resources into ensuring efficient and effective information sharing practices through the development of new risk based approaches and enhanced referral desk capacity. SC&O5 have collated information that shows these new practices have identified victims and allowed for safeguarding interventions which may have been missed previously. All SC&O5 training, but in particular the multi-agency training, focuses on minimising the risk to children through appropriate information sharing and empowering staff to use and develop their professional judgement. SC&O5 have also recognised that this needs to be supported by strong supervision. SC&O5 has changed its structure to ensure sergeants, in particular, are able to offer support and guidance to staff managing cases. These workloads are reviewed annually to ensure an appropriate distribution of resources.

Borough Police

This annual report highlights some of the work and multi-agency involvement in Safeguarding Children within Hillingdon Borough involving the departments of the Metropolitan Police (separate report from SCD (2)).

A large resource intensive part of this work is the Missing Person's Unit's investigations to locate, return and debrief missing children. During the period 1st April 2012 - 31st March 2013 there were a total of 750 missing Children under the age of 18.The breakdown of some of these statistics is that 24 were High Risk, 658 were Medium Risk and 68 recorded Standard Risk. There is a caveat that several of these Missing Children go missing on multiple occasions and often more than once in the same day.

These recidivists are subject to scrutiny and intervention plans when discussed at Missing Children Operational Meeting.

The Missing Person Unit has been relocated in the Grip & Pace office at Uxbridge Police station to maintain and enhance the response to Missing Children in Hillingdon.

A search to assist with the impact of Crime within Hillingdon Borough on children under 18.

Within the year there were 1948 crimes with victims under 18 years of age.

The Public Protection Desk recorded during the year Pre Assessment Checklists/Pre birth PACS in total 4508.

A breakdown of that is Apr 310,May 456, Jun 424, Jul 416, Aug 334, Sep 313, Oct 375, Nov 368, Dec 314, Jan 436, Feb 366, Mar 396.

Significantly, the Public Protection Desk footprint has been transported to the Multi-Agency Safeguarding Hub, M.A.S.H. located in the Mezzanine at the civic centre, after more than a year of planning.

This is a significant development in multi-agency working which involves a Police Sergeant two police constables and two researchers being co located with social workers to enhance the process of protecting the most vulnerable.

This has all remained focussed and constant with the Metropolitan Police radically restructuring under the Local Policing Model without loosening grip on such an important priority**.**

Work also continues in respect of liaison with specialist units to prevent and or detect sexual exploitation of children.

Multi-agency public protection arrangements (MAPPA) in Hillingdon 2012/13

MAPPA is responsible for the risk assessment, management and planning for cases under the following criteria:

Category 1: All registered sex offenders.

Category 2: All violent offenders sentenced to a custodial sentence of 12 months or more for a violent offence listed under schedule 15 of the Criminal Justice Act 2003; subject to a section 37 Hospital Order for a violent offence; any sex offenders who are not registered.

Category 3: Any offender with an eligible previous conviction (violent of sexual offence) who presents a high risk of serious harm to the public and the case requires multi-agency risk management.

This year has been another busy year for Hillingdon with up to 21 referrals received per month, under the three categories above. The cases are managed at 3 levels:

Level 1: Single agency management;

Level 2: Active multi-agency management;

Level 3: 'The Critical Few', requiring management by senior staff with the authority to commit extra resources to managing the risk.

Prior to January 2013, all eligible cases in all categories were screened by senior members of the 'Responsible Authority' for MAPPA, being police and probation, who then set the MAPPA management level.

From January 2013, all referring agencies to MAPPA – police, probation, mental health services and youth offending service screen their own cases and decide what risk level they will assign as the lead agency holding the case. This new way of working across London has brought Hillingdon and London as a whole into step with how MAPPA has always operated in the rest of England & Wales. This way of working keeps the responsibility for setting a risk level of 1 with the agency holding the case and improves risk assessment and practice in these agencies, rather than reliance upon police and probation to exclusively hold this area of expertise.

There have been two cases managed at level 3 for a number of months during 2012/13, involving senior members of staff and involving complex issues of both child protection and the risk management of child offenders. Safeguarding is not always just a matter of protecting the vulnerable from others. Sometimes, the vulnerable, such as children, can present considerable risks of committing abusive sexual and/or violent acts against other children, staff and others. We have managed two such cases this year, with Hillingdon council devoting considerable resources to place one such child in specialist foster care. Health has commissioned specialist assessment.

Since moving over to the new risk level setting arrangements in January 2013, MAPPA in Hillingdon has assessed and set risk management actions on a monthly basis for an average of 15 cases a month. Cases managed at level 1 by the case holding agency do still involve information sharing between relevant agencies and can move in and out of level 2 or 3 at any time, as required.

The issues typically addressed at level 2 meetings involve disclosure under controlled circumstances to third parties, including the parents of children, of an offender's status as a registered sex offender and the attendant risks posed. Decisions are made about where someone can be housed on leaving prison to avoid victim contact. Prison licence conditions are discussed and agreed to set limits on an offender's movements and associations, or compel treatment or completion of specific offending behaviour work to reduce the risk of harm from offenders to others. All agencies check the information held on a level 2 MAPPA subject and share their knowledge with each other.

Financial arrangements

The LSCB is funded in partnership by the following agencies: Hillingdon Council, NHS Hillingdon, Metropolitan Police, Probation, CAFCASS, and 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 is always under pressure due to the need to carry out independent reviews.

The UK border agency also contributes through an overall grant made to Hillingdon Council, as a contribution towards safeguarding the needs of vulnerable as a Gateway Authority.

It should be noted that, in addition to the financial contributions, considerable in kind contribution is provided by the Council through use of staff time within Children's services.

4. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Reviews (SCRs)

There were no Serious Case Reviews carried out in Hillingdon during the year.

However, five cases were considered by the SCR sub group and, although the criteria for serious case review were not met, each case was followed up in a proportionate way in order to generate learning.

Two cases involved children with disabilities. One, involving a young man who had expressed concerns about his care, was subject to an independent review in which he was fully involved. This review highlighted some good practice in that the Children with Disabilities Team had placed DD on a CP Plan and had responded to the situation of neglect at home using child protection procedures. However, there was evidence that all agencies collectively had not intervened early enough in DD's life, concentrating rather on single agency issues such as housing, physical aids (occupational therapy) and support of the parent, rather than recognising the child's voice and the neglectful circumstances in which DD had to live his life during his childhood. The learning from this Review has been fed into the work stream of the Children's Pathway Programme (CPP), which is now focused on special educational needs, disabilities and transition.

The second was a child with child protection plan who died unexpectedly from a life limiting condition. Good practice was identified in this case with recognition of risk factors and good communication within the core group. Any further learning will be fed back through the Child Death Overview Panel (CDOP). This will be fully reviewed by CDOP later in the year, once all information is received back from the Coroner's Office.

Two cases concerned adolescents, one of whom sadly took their own life. In both cases mental health services were provided, and in one in particular the all too common theme of long standing neglect was a feature. In both cases the main issues raised related to the issue of trying to identify and provide appropriate support at an early age through early intervention services. A multi-agency case audit review is taking place to identify further learning in one of these cases. This will be carried out in the next round of multi-agency audits in the Autumn of 2013.

A further case, of the unexpected death of a young baby, raised learning issues that will be used as a case example in the development of early intervention services and key working. The family received a range of services at different times but it was felt that they could have been coordinated in a more helpful way – although there was no association between services received and the baby's death. Some useful systems were put in place immediately by Council Housing staff and a Housing agency to enable better identification of potentially vulnerable families.

The cases in Rochdale and more recently in Oxford have continued to have considerable national resonance. The Rochdale case raised the issue of the

particular vulnerabilities of young people (young women in this case) looked after in respect of risks of sexual exploitation particularly as a result of going missing. The Government responded swiftly and a parliamentary Select Committee investigation took place with a report and recommendations published in summer 2012.

A survey of Barnardo's services in England and Wales, published in May 2013, revealed just how difficult it is to secure convictions in sexual exploitation cases. During 2012, of 56 known police investigations, only 15 have resulted in prosecutions so far. Of these 15 prosecutions only six have so far brought about successful convictions.

Part of the problem is in recognising when difficult behaviour in adolescents masks vulnerabilities and abuse, and in ensuring that young people have confidence in the systems there to support them. Convictions were only secured when young people came forward to give evidence. These are usually young people with complex needs and the Oxford trial did also emphasise some of the efforts that social workers had made to safeguard them.

Last year the Policy Overview Committee (POC) carried out a review of children missing from care, and recommendations were picked up by the sub groups of the LSCB. One of these sub groups considers all young people who are at risk of going missing, being exploited or trafficked. In Hillingdon, the multi-agency sub group for Child Sexual Exploitation (CSE) and Missing Children has considered carefully the implications of the Oxford case in terms of sharing information and local intelligence about possible CSE with all care providers in the Borough where there are vulnerable children and young people in placement. The recommendations are as follows:

RECOMMENDATION 1 – That the written guidance for staff in residential homes on what to do if a child goes missing from case, be revised and reinforced, to ensure that the information shared with the Police incorporates all information needed to help find/trace a missing child, including mobile phone numbers, oyster card numbers and known addresses.

RECOMMENDATION 2 – That the written guidance should also be extended to all staff working in private care homes, voluntary care homes and semi-independent units for children in the Borough.

RECOMMENDATION 3 – That the Local Safeguarding Children's Board be asked to extend multi-agency training on missing children to foster carers and residential staff from the private, voluntary sector and semi-independent units in the Borough.

RECOMMENDATION 4 – That the Metropolitan Police public protection desk in the Borough be asked to produce biennial statistics on the prevalence of children reported missing from six "care homes" across the Borough, and if possible extend this to include all foster placements placed in the Borough by other local authorities.

RECOMMENDATION 5 – That officers be asked to explore the findings of the review and feasibility of adopting the following:

- To explore the viability of introducing a system of dealing with the children who were repeatedly reported missing without involving the Police in the first instance.
- To investigate the use of the Multi-Agency Safeguarding Hub (MASH) as a means through which to share intelligence on missing children and, ultimately, to reduce the number of children going missing from care. Included in the MASH should be a representative from Education who could provide information on Looked After Children who were not attending school.
- To explore the possibility of the mobile youth services bus being made accessible for children in all local authority, private and voluntary organisations care homes.
- To consider the possibility of harmonising the terminology used with regards to missing people across all organisations in Hillingdon. This would help to ensure that the reporting of cases and collection of useful data would be improved and made more accurate.
- For the Local Safeguarding Children's Board (LSCB) to review statistics on children missing from care in the Borough twice annually

The five recommendations listed above have been considered and, where possible, implemented via the integrated Child Sexual Exploitation and Missing Children sub group of the LSCB. To a large extent these recommendations anticipated the changes in National Guidance, Policy and Procedures which have required greater emphasis on safeguarding Looked After Children placed out of Borough, particularly in relation to their vulnerability to exploitation as a result of going missing. The LSCB main board in Hillingdon receives quarterly reports on children reported missing, not just those who are looked after by Hillingdon, but also those placed within the Borough of Hillingdon by other local authorities.

The Ofsted requirements on reporting missing children placed in residential care do not permit a system for 'non-reporting' of children who go missing from placement, but whose whereabouts are known. It has therefore proved difficult to make viable the first recommendation from the POC review.

The Multi-Agency Safeguarding Hub (MASH) is in a 'soft-launch' mode, and is exploring how best to share information about children reported missing that focuses on levels of risk but with reduced recording of recidivist missing children whose whereabouts is known to agencies (e.g. they may have gone home without permission).

Youth Services are accessible to all children in the borough, including those in local authority and private and voluntary organisations. However, the mobile youth service is a very limited resource, and is targeted at vulnerable children who have particular difficulties with travel facilities, due to geographical location. This does not ordinarily apply to children placed in the care homes.

There remains on-going difficulty around harmonisation of terminology. This cannot be resolved locally, as agencies have policies and procedures about 'missing people' which are determined by National Government (e.g. Home Office, Department for Education, Ofsted). The focus locally has been

ensuring that associated risk indicators are used to determine the response to a child reported missing from home or care, and this has proven to be more useful from a safeguarding perspective.

As already noted, the Local Safeguarding Children Board is now receiving quarterly reports on the number of children reported missing in the locality, as part of the data set used to monitor effectiveness of practice.

In spring 2012, a root cause analysis, management review was conducted jointly by Children's Social Care and Adult Mental Health Services. This was commissioned after a parent hanged himself, shortly after his children had been taken into foster care after he admitted having harmful thoughts towards them. There were several recommendations for the agencies involved but, in the main, the joint learning was around better communication and more effective collaboration between professionals when working with parents suffering from a mental illness. The learning from this review was presented to senior representatives of all agencies at the Hillingdon LSCB and also through action learning sets and briefings at Hillingdon Hospital for managers within the Adult Mental Health setting and within Children's Social Care.

As a result of this review, the protocol between Mental Health Services and Children's Services has been re-launched and a reciprocal consultation surgery has been set-up between operational teams within the two agencies. This initiative has promoted better knowledge and understanding of how to assess risk jointly when parents are experiencing enduring mental health issues. This learning will be highly relevant in the new Multi-Agency Safeguarding Hub (MASH) once it is commenced in the Autumn of 2013.

Risk Management Panel and multi-agency case review

In February 2012, a multi-agency Risk Management Panel was established to address the safeguarding issues related to high risk cases identified by partner agencies. It was established following a case review which identified the need for an escalation process for complex and high risk cases that appeared 'stuck' even when all appropriate channels had been explored. High risk was defined as cases which were highly complex and/or subject to drift. The Risk Management Panel meets six times a year and has its own terms of reference which includes a focus on learning lessons for practice from the issues identified at the Panel meetings. All partner agencies are represented at the Risk Management Panel, including Social Care, the Child Abuse Investigation Team, Health Provider Services, Education and a Council legal representative. Where needed, Adult Mental Health Services for substance misuse and parental mental illness are invited to the Panel on a case specific basis. Schools are also able to bring forward high risk cases via the CP advisor for schools, if they have become stuck.

At the first two meetings the panel reviewed eight families whose children were all subject to child protection plans with neglect being the predominant category. These cases were put forward as they were deemed to be "stuck" and had complex family problems at their heart. The Children's Social Care CIN Team Manager was present, supported by the Service Manager to ensure that action plans were developed for each case and the panel all reviewed their plans at subsequent meetings. Key themes that emerged at

this point were around thresholds for care proceedings and in many cases the need for chronologies.

The Panel then amended the terms of reference (TOR) to ensure that case auditing would have greater prominence, and to focus specifically on learning from practice, especially in relation to high risk cases. It was envisaged that this panel would provide an opportunity for key partner agencies within safeguarding to review their responses to high risk cases, learn from the experiences of practitioners and help to drive up standards in practice. This learning would be disseminated across the partnership within the LSCB. In order to preserve its operational remit, the revised Terms of Reference included a caveat to ensure that the Risk Management Panel will remain a mechanism for escalating cases. The Risk Management Panel will only consider raising cases with the LSCB once all other efforts to progress the case or resolve any conflict have been exhausted. Proposed future work was to target ineffective child protection planning, plans over three years, especially if parental mental health issues and domestic violence are featured and track any themes that may emerge. The impact of the high turnover of staff in Children's Social Care, especially in core groups was a raised as a complicating factor and also the child protection case conference process in Hillingdon. The conference process was being addressed by the Service Manager and by all agencies to ensure that child protection plans would become more outcomes focused.

In 2013, the Risk Management Panel identified eight children who meet criteria for inclusion in the case mapping exercise that would be expected in any peer review. An audit tool was developed exploring nine key areas. The panel have used meetings to analyse the data received from the participating agencies, and emerging themes are:

- Improved analysis and planning evidenced in some cases.
- Multi-agency collaboration and communication evidenced well on the whole.
- Domestic violence remains a strong indicator of risk to children, which impacts most significantly on their emotional development.
- Access to resources for perpetrators of domestic abuse has improved, but remains limited in the locality.
- Developing 'smart' child protection plans for children who have been neglected or emotionally harmed is challenging, and can result in 'monitoring' type activities, which are not effective.
- Cases do tend to 'drift' whenever there is a change of worker, as the changes are often not communicated effectively within the core group of professionals and are not communicated to the family.
- The voice of the child is rarely appropriately evidenced in case records.
- Supervision and management oversight is inconsistent across all the main agencies, and multi-agency panel discussions not consistently recorded.

Audit of social care files

During the year, two reports (November 2012-April 2013) were presented to the Policy Overview Committee reporting the findings from the quality audits programme. There was a steady improvement noted in the quality of social work practice, file recording and staffing stability. This was driven by the impetus of the Children's Pathway Programme with its emphasis on new ways of working, reduction of bureaucracy, and professionalisation of the social work teams, in line with the Munro recommendations. The Social Work Conference, held in September 2012 in Hillingdon, promoted membership of the College of Social Work on a corporate basis with a strong local commitment to the implementation of the Social Work Professional Capabilities Framework within the Borough.

Social work activity during this period was particularly effective with a significant number of Child Protection Plans being discontinued and stepped down into lower tiers of service in Children's Centres and Universal Services.

With some posts covered by agency staff, and the number of newly qualified social workers recruited, management oversight is a critical and sometimes variable component of case management. As noted earlier, reflective supervision training has been provided and the supervision policy has been refreshed and updated. The 'POD' system of working in small groups has received positive comments from staff and it is hoped that this will also improve case management and oversight. This will be followed up by case audits in 2013-14.

Child Death Overview Panel (CDOP)

In spite of in-year fluctuations there were no significant changes in numbers of child deaths in Hillingdon. The CDOP continued to deliver important public health messages from local and national cases. The issues of sleeping arrangements continued to cause concern as an associated factor in sudden unexpected infant deaths, and this has been confirmed as a national issue by recently published research. Evidence indicates that all families are given relevant information about this issue and the LSCB is pleased to note that this is likely to be pursued at national level.

Appropriate cases of concerns were brought to the attention of the LSCB and followed up by consideration at the SCR sub group or, in one case, by follow up with a school and LSCB in another area.

Recently published data from DfE identifies that the highest proportion of 'modifiable factors' (i.e. associated but not causes) came among those aged one month-one year, and those aged 15-17. The findings for young babies are likely to reflect previously identified issues to do with safe sleeping etc. The findings for those aged 15-17 are likely to reflect the most common causes of death in that age group, i.e. road accidents and suicide. We have already referred to suicide as a significant issue among young people who have experienced long term neglect.

Overall, there is evidence from our case reviews and audits that there is good multi-agency collaboration and practice, particularly once child protection

concerns have been identified. Assessment, analysis and planning also indicate improvements.

Staff shortages potentially put this at risk and management oversight is not always consistent or recorded well. The same applies to the child's view, which may be implicit rather than explicit in case recording.

It is clear from cases looked at that problems often still become apparent very late, particularly where children are experiencing domestic violence, or neglect.

This highlights the importance of early help services in identifying and helping. Of particular relevance here is the need for earlier mental health support for children before they reach the potentially high risk adolescent years.

Use of social care thresholds remain sometimes unclear though it is hoped that this will improve as clearer guidance is rolled out, and as early help services develop and mature.

Ongoing dissemination of learning

Learning from local and national work has been fed back to staff in various ways. Key messages are incorporated in multi-agency training and passed on through staff meetings and the LSCB conference. There is a steering group for reflective supervision and front line managers attend regular safeguarding managers meetings and LSCB sub groups, all of which are used as ways of passing on learning.

5. WORKFORCE

Evaluation of single and multi-agency training

Introduction to Safeguarding training

Safeguarding Introduction Training (level 1) is compulsory for all employees in the workforce who directly or indirectly work with children. Many agencies, including Hillingdon Health, CNWL, Hillingdon Hospital Trust and the Metropolitan Police have their own tailor-made training, frequently delivered by named heath professionals. Health partners are confident that staff who require this level of training are trained and that effective governance mechanisms are in places to ensure compliance.

Local Authority staff, schools and the voluntary sector tend to use the e-learning package offered by the LSCB. In 2012/13 the LSCB issued 1327 licences to a large variety of agencies, the majority of which were issued to schools. 2012/13 figures were more in line with 2010/11 figures with 635 fewer licences issued compared to last year.

	2010/11	2011/12	2012/13
Annual conference	196	161	136
e-learning	1511	1962	1327
Training	1081	1181	935
Total	**2947**	**3304**	**2398**

Statutory training

As in previous years, multi-agency safeguarding training was the mainstay of the LSCB's training package in 2012/13. This training is intended for staff who work intensively with children (level 3) who are subject to multi-agency intervention strategies such as child in need or child protection plans. The LSCB offers training in two parts: *Working Together to Safeguard Children* (level 3, identifying and responding to safeguarding concerns, referral process and information sharing, statutory guidance and local procedures up to the point of a child protection case conference). The next course is *Core Groups and Child Protection Plans* (Multi-agency assessment, planning, intervention and reviewing process of children who are subject to CP plans).

Evidence has shown that the benefits of training staff together are: clarifying the roles of different professional and agencies, creating opportunities for staff to meet each other and, most importantly, to clarify expectations and myths that may get in the way of successful multi-agency working. It is the LSCB's expectation that managers identify staff who require this training and ensure that they attend.

Refresher training

The LSCB offers *Working Together Refresher* training for staff every three years to ensure that they remain up to date with legislative and procedural developments, research and recommendations from national Serious Case Reviews, as well as local SCRs and management reviews.

In 2012/13 the LSCB offered 12 training days and 500 places for Working Together / Refresher training and most places were taken up. The training numbers for Refresher training were lower than that for *Working Together* which raises the concern that staff may not be attending refresher training as frequently as required and that some (about 10%) attend the full day training course again.

Schools and the health sector have strict guidelines about the frequency of refresher safeguarding training, which was borne out in their attendance: 44.2%, followed by schools (32.6%), LA (13.9%), Voluntary Services (8.1%) and Mental Health Trust (1.2%).

Multi-agency training was offered to more than a 150 different agencies / schools and nurseries. The private and voluntary sector, education and health were very well represented, taking up the majority of places. Several agencies have expressed the wish that more statutory agencies attend training and that will be addressed in the work plan for 2012/13.

The LSCB have offered fewer statutory training days in 2011/12 because of the expected (but considerably delayed) statutory guidance, *Working Together to Safeguard Children 2013*. In response the LSCB will increase training opportunities in 2012/13 to train staff in the new statutory requirements.

Training evaluation framework / feedback

This year, the NSPCC's training evaluation toolkit *Connect, Share and Learn* will be introduced to understand the impact of training. This is a standardised evaluation tool that attempts to measure the extent to which courses raised the knowledge and competence of students. The toolkit may need to be adjusted because of changes in statutory and local guidance, but the impact is not yet clear.

The LSCB have analysed the results of post-training questionnaires and evaluations. More than 94% of attendees thought that LSCB courses delivered on advertised training objectives. A few students (6%) were hoping to hear about the imminent statutory changes to Working Together guidance.

90% of attendees thought courses covered what they were expecting, 10% though the content could have been better if it included an update on Working Together legislation. Even so, 88.2% rated the level and amount of content as good or very good (32.9%, 55.3%), average (9.6%) and poor (2%).

Overall, most attendees (95%) were pleased with the quality of tutors for statutory training, thinking them to be very good or good (70%, 25%). No one thought the tutors were poor or very poor. Tutors' knowledge about their subject areas showed similar results (very good 76.8%, good 23.2%).

This year saw the introduction of a new on-line course booking system which initially produced some growing-pains as people were adjusting to a different way of registering for courses. 83% of respondents thought the system was very good (35%) or good (45%).

Anecdotal feedback about statutory courses:

"When I have to be involved in core group meetings, case conferences, I shall know what to do."

"Overall a very good course which was practical and informative..."

"I have a much better understanding of the thresholds involved in referrals."

"An excellent and engaging course. I thoroughly enjoyed the course and feel that I am much better equipped to make decisions..."

"...more confident with the process if I ever had to report or ask for help if I suspected any child of being abused."

"Excellent course, good activities good networking opportunities, attendance by different agencies and having to work on activities with each other."

“I am now able to understand the correct procedures and act on this when/if I am put into a child protection situation.”

“I feel much clearer in my understanding of how to proceed should a safeguarding issue come to light in my area of work with palliative patients, their families and carers.”

6th Annual LSCB conference

This year slightly fewer people attended the LSCB conference due to an unavoidable change to a smaller and more remote venue. The programme covered the following areas:

- John Pitts spoke about the development of gangs, the themes that create an environment that supports and perpetuates a gang culture and approaches that have been taken around the country that have had an affect in reducing gang activity.
- James Blewett presented the learning from Serious Case Reviews (nationally) and management reviews (locally).
- Helen Bonnick presented on the features of parent abuse and the dilemma for practitioners in addressing the issues for both the parent and the young person/people.

Most conference attendees found the day useful, especially the presentation around national / local learning from serious cases and gangs. LSCB conference are always well attended by a large variety of agency including LA, Health, UKBA, the Metropolitan Police, Schools, Nurseries and the Private and Voluntary sector.

Stakeholder day

In order to enhance engagement with front line staff, a stakeholder workshop took place in May 2012, which was attended by 51 front line managers and key practitioners across all key agencies. The interactive session consulted on the LSCB priorities and on recently published research studies from the Department of Education (DfE). There was a lot of useful feedback, much of which is reflected in this report and in our Business plan.

Those attending agreed with the main Board priorities but emphasised the importance of those children affected by mental illness, substance misuse and/or domestic violence. Concerns were expressed about the availability of CAMHS services, particularly for young people experiencing neglect and those demonstrating risky behaviours.

Understandably, workload and recruitment and retention difficulties were felt to be risks to safeguarding. Other issues raised were:

- The need to strengthen early intervention services, whilst maintaining consistent thresholds.
- The need to carry out more joint assessments at an early stage, and to include adult services in these.
- Recognition that the Common assessment framework (CAF) was still proving problematic as a mechanism for referral or promoting intervention.

Since that time, practitioners have been able to contribute to the development of the shared early help assessment and referral process, and early intervention services have been reorganised as part of the children's pathway programme.

- The need to engage with GP services and commissioners.

The engagement with commissioners will be developed through the CCG membership of the LSCB, though engagement with GPs as providers is still identified as a work in progress

- Multi-agency training was acknowledged to be high quality but more specialist training was requested on key areas.

This has been followed up as much as possible through the multi-agency training programme

- A request for improved communication about important safeguarding issues.

This happens through line management channels but remains an issue for the LSCB. A staff survey was sent out in July 2013 and will be followed up by a regular bulletin

45 staff responded to the survey, spread across most of the key agencies working with children. 89% agreed with the LSCB priorities; the rest were 'unsure.' There were some additional comments but these related mainly to issues that are contained within the 'small print' of the LSCB business plan, e.g. trafficking, mental health.

Some concern was expressed about social care thresholds. Just over half of respondents (56%) said they used them (though 20% weren't sure) 38% felt they were clear and 20% that they were not (40% unsure). It was not possible to correlate both sets of responses but clearly there is more work to be done here. Thresholds have recently been refreshed and updated, and more remains to be done. Further comments indicated that particular attention should be paid to ensuring that the thresholds are clearly written and easily accessible, and that they have more detail about specific issues, particularly domestic violence and disability.

Staff were asked about what they thought were the most and least effective contributions to safeguarding.

Respondents to the survey helpfully highlighted Signs of Safety as being a positive development, alongside the framework around child trafficking, and the support given to agencies about safer working practices. Training and multi-agency communication and working also received many most positive comments.

Fewer respondents had negative comments but bureaucracy and lack of communication received most responses in terms of things that were not effective, along with the implementation of the CAF. There was also a body of comments that more focus needed to be given to early assessment and help, and better joining up with adult services.

Overall, there was general endorsement of the LSCB priorities. There was also endorsement of the key themes picked up in the LSCB business plan and children's pathway programme.

It is clear from the responses that the early help assessment and alignment of pan London levels of need should be prioritised within the workstreams of the LSCB. In addition, the implementation of Signs of Safety and consolidation of work around key risk issues, such as mental illness, must continue.

Implicit in many of the responses was an emphasis on communication, and liaison across agencies.

In times of straightened resources, this is an important message, as communication requires time, but is clearly very much worth it in its contribution to safeguarding.

Capacity: Workforce and Staffing in Children's social care

The number of front line social work posts in the establishment of Children's Social Care has been increased as a result of the discovery, design and implementation of the Children's Pathway Programme. This is helping to manage the demand on front line services and improve the quality of work. Overall there has been a gradual improvement of stability in the workforce, led by the Current director of Children's Services, and her senior management team.

However, because there are now more posts in the establishment it has been challenging to get experienced social workers and managers into permanent posts, and some pressure points are still present, even within the stabilisation that has occurred over the past

As at June 2013 there were 44 vacancies, of which approximately a third were at senior social worker level or above. Although many of these posts are filled by competent locum staff this does raise a major concern about the Council's ability to provide effective supervision and management oversight, which tend to be recurring themes in local and national case reviews.

Creative recruitment campaigns are now being conducted through Council internal communications team, a dedicated Human Resources (HR) officer, and the HR Business partner for Children's services

Allegations against Professionals

The Local Authority Designated Officer (LADO) role is outlined in Chapter 2 Working Together March 2013 and under the organisational responsibilities in Section 11 of the Children Section 2004. It emphasises the requirement for organisations to contact the LADO regarding an allegation against any member of staff within one working day of it coming to the employers' attention, or where allegations are made to the police.

The referrals to and consultations with the LADO have remained consistently high throughout the year (2012-13), indicating that agencies are utilising the service appropriately and in line with their own safeguarding procedures.

There have been 105 referrals to the LADO during this period which have required a strategy meeting. In addition, advice has been given about dealing

with allegations which did not meet the threshold for a meeting in relation to 71 cases.

A not surprising increase has been in historical allegations linked to the publicity about the Savile investigation, all of which have to be followed up with the same rigour as recent allegations.

The continuing high number of allegations indicates an appropriate awareness and response. However, it also indicates that determined people can continue to access organisations and that some staff can still behave inappropriately towards children and young people in their charge.

The LADO continues to liaise with colleagues in Ofsted, the Disclosure and Barring Service and the Police, in order to effectively manage the allegation process. During the year 5 criminal convictions were achieved; others received suspended sentences and had their names placed on the sex offenders register.

These allegations have highlighted the importance of keeping accurate records, even when concerns about staff conduct appear to be low level and insignificant in isolation.

The biggest proportion of LADO type work involving allegations against staff are through Hillingdon schools and academies. The head teachers' fora have been extremely complimentary of the support and help received from the LADO.

The LADO delivers a continuous programme of training and consultation with all local agencies and organisations. This has, and will continue to, include the changes to be implemented to the vetting and barring regulations by the Disclosure and Barring Service (DBS).

6. 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 spreadsheet that picks up and monitors all actions arising from inspections audits etc. It is monitored at each LSCB meeting and completed actions are signed off by the Board. During the year 39 actions were completed and signed off by the Board. There were 25 actions progressing at the start of the year, and 22 by end March 2013, as actions were completed and new ones added on.

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 usually asked to complete an annual return to the LSCB identifying their internal audit programme and consequential actions taken. This year that was replaced by the section 11 audit. This was reviewed by the performance sub group. Following the serious case review, schools are now asked to complete a bi-annual safeguarding audit for the LSCB. These are reviewed by the Education officer and reported to the LSCB.

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.

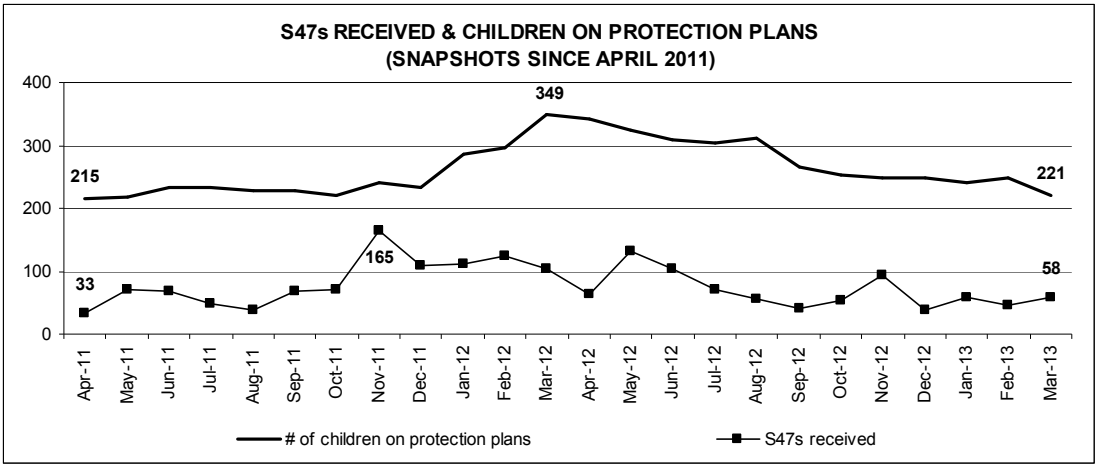
Effectiveness of local arrangements to safeguard children

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

Child protection activity

This section is based an annual returns for the year 2012-13.

During 2012/13, the numbers of CP enquiries reduced compared to 2011/12 (-20%), as did the number of children on CP plans (-37%). Both of these indicators have stabilised in recent months but despite this decrease, levels of demand are still higher than levels experienced in 2010/11. These trends are illustrated in the chart below:



Performance against the various child protection indicators remained good with a slight reduction in those on plan for more than two years. Timeliness of initial child protection conferences was good (97.1%) though slightly down on the previous year. Timeliness of CP statutory visits has been maintained during the year, with 97% of visits on time.

It should be noted the overall number of children subject to child protection plans throughout the year is not a static cohort. During the last year (2012-2013) there has been a significant turnover of children coming off CP Plans (334), and new children coming onto CP plans. Positive outcomes are being noted for children coming off plans who have been safeguarded, and protected, and evidence of this is being seen in the independent audits being carried out by the safeguarding Children and Quality Assurance Service. However, further work needs to be undertaken to ensure that this is consistent, and is then tracked through the whole of the Children's pathway to ensure that these outcomes are sustained.

The gender of children subject to a Child Protection Plan is virtually evenly split between Males 51% and Females 48% with 1% unknown, as they were unborn at the time of registration.

The age distribution of children on a Child Protection Plan reflects the general population of Hillingdon, which has a growing number of younger, school age children, with 83% of children on plans being under 12, with 35% being under 5, as a whole. Also significantly, there has been a rise in the number of older children, between 13 and 15, made subject to a CP Plan compared to the previous year. This represents the growing awareness of exploitation and risk outside of the family to which adolescents and teenagers are susceptible.

The ethnicity of children made subject to a plan reflects the census data for the Borough, showing a rise of children and families from non-white English backgrounds, especially Polish and Asian families.

The largest category for children on CP plan is emotional abuse, when taking into account the combined categories for registration. This reflects the growing awareness among professionals, and within the community, of the long term impact on development of those children exposed to domestic abuse.

Overall, the number of children on a plan for neglect remains high and is still the single most concerning indicator of child abuse. This is significant, given

the age distribution, with more children under 5 being subject to Child Protection Plans. This highlights the need for earlier intervention both in terms of child's early life, and also in terms of dealing with the issues early, to prevent the corrosive damage done by neglect, as shown by the research evidence linked to brain development.

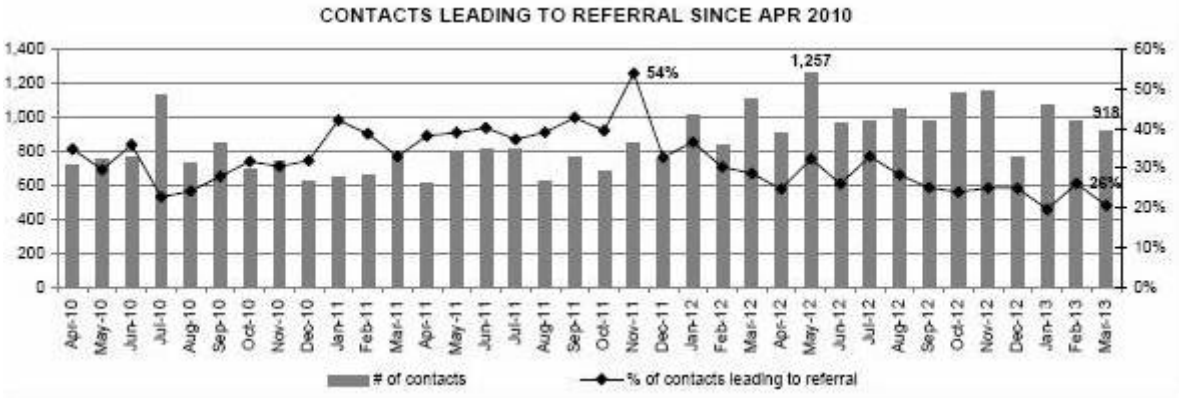
In response to these issues, the LSCB has developed refresher training on countering neglect and early intervention, for families where children are exposed to domestic abuse and chronic neglect.

Social Care activity

There were 100 more open cases and more core assessments noted in the census returns, although referral figures and child protection activity was stabilised. A greater number of children in need cases is being worked with below Child Protection, after being stepped down from a child protection plan. More consistent application of the pan-London Continuum of Need has helped the triage process within Children's Social Care, both in relation to signposting needs that do not require statutory intervention and also ensuring that the correct cases are given attention as children-in-need, even if they have not reached a child protection level of concern. Completion of assessments within timescales was down, although this did improve in the second half of the year. These timescale indicators have changed from 2013.

A possible explanation for the trend above is that there may have been a reactive response to the Ofsted pilot inspection held in November 2011 (resulting in a higher likelihood of a contact becoming a referral and a sequential effect on the number of children on child protection plans). Since then, there have been a number of improvements in management practices, and anecdotal feedback from managers indicated a greater level of confidence and consistency in decision-making, particularly in the early stages of the pathway (e.g. when applying thresholds).

A further example of more consistent practices is illustrated in the chart below which highlights a noticeable peak in the percentage of contacts becoming referrals followed by a steady reduction and eventual stability towards March 2013 (at around 20-25%). Once more, this highlights the benefits of improved triage and activities associated with CPP work streams (e.g. inter-agency referrals, better management of contacts).



Increases in demand are noticeable in some other indicators which occur further down the children's pathway. Specifically:

- Overall, there have been increases in the number of statutory visits carried out, particularly in relation to the number of LAC stat visits (+40%). This will have been influenced by the higher number of looked after children, particularly in the early part of the year.
- Timeliness of statutory visits has improved for LAC, with 81% of visits occurring within the expected timeframes (an improvement of 4%).

Children at risk through trafficking or sexual exploitation

The Local Safeguarding Children Board sub group dealing with exploited and trafficked children has continued to thrive. Membership includes representatives from national government organisations, such as End Child Prostitution & Trafficking (ECPAT) and the Child Exploitation & Online Protection Service (CEOP). The co-operation of UK Border Force staff has been crucial in ensuring the effective screening of children for issues of trafficking, arriving at Heathrow Airport, and UK Border Agency also remains a pro-active member of the sub group.

Sitting underneath the trafficking sub group are two operational groups, which meet on a more regular basis. The first operational meeting involves looking at the profiles of all children who have arrived through the airport terminals and identifying issues of trafficking or exploitation. By this process, a number of children have been identified as trafficked, and referred to the UKHTC (UK Human Trafficking Centre) via the National Referral Mechanism (NRM). Some of these children were age disputed and were deemed adults on the basis of the age assessment carried out by the local authority and partner agencies, but nevertheless they were vulnerable due to trafficking issues. In total, 11 NRM referrals were made during the year, including 3 young people deemed to be an adult. The collaborative work between the social work teams and Paladin (law enforcement) resulted in a number of court cases, which had positive outcomes in terms of disrupting the trafficking networks and safeguarding individual children.

The other operational group which sits beneath the Trafficking Sub Group is the multi-agency meeting that addresses issues relating to children who are reported missing within the community. This group includes active involvement from the Public Protection Desk of the Borough Police, and also has engagement from the Youth Offending Service, as well as the front line social work teams and registered care managers of children's homes in the locality. This meeting has identified a small cohort of approximately twenty children (mainly local children) who lead risky lifestyles through repeated episodes of being missing from home or care. The operational group has focused on collaborative interventions and has ensured that proper risk assessments are undertaken with this group of children.

Overall, the number of children going missing throughout the year has declined from 7 to 3 young people who have not been located after arrival at the airport. The London Safeguarding Board has a sub group for countering child trafficking across the capital. This sub group is chaired by Hillingdon's Head of Children's Safeguarding and Quality Assurance in recognition of the expertise in child trafficking in this local authority.

Hillingdon's model for countering child trafficking was commended nationally and cited by the Home Office in its Anti-Traffic strategy. For this reason, representatives from the Hillingdon LSCB were called to give evidence in the All Party Parliamentary Group in February 2012, for analysing the national policies for reducing the incidence of children missing, especially those at risk of being trafficked. This is testament to the continuing standards of best practice maintained by the Hillingdon LSCB.

Further high profile interviews and documentaries are envisaged in the coming year, highlighting the successes made in Hillingdon.

Private Fostering

The number of children in private fostering during the year has been relatively low (10) and represents an ongoing area for development. The Local Safeguarding Children Board has continued to deliver briefings and multi-agency training on the need to identify situations of private fostering. This has been beneficial for UK Border Agency staff at the airport terminals who have been able to notify local authorities other than Hillingdon when children are being placed in private fostering situations across the UK.

In Hillingdon itself, there are more than ninety schools, including academies and independent schools. The challenge, given to head teachers, has been for each school to examine its admissions roll and identify at least one child who is being privately fostered. This is work in progress and, so far, has not resulted in additional notifications of private fostering situations. The research evidence shows that private fostering is often a key safeguarding issue for profiling children at risk of trafficking, child sexual exploitation and exposure to domestic servitude or exploitation in the catering industry. This remains a priority for the Local Safeguarding Children Board. In the coming year, the local authority is hoping to recruit a specialist worker, based in Children's Social Care, to help raise standards in private fostering across all partner agencies.

Disabled Children

The levels of awareness about child protection and child safeguarding within the Children with Disabilities Service has continued to grow during the course of the year. Although the number of children with disabilities who are subject to a child protection plan is still not growing sufficiently to demonstrate that this vulnerable group of children are being adequately protected, there is still nevertheless a rise in numbers. During 2012/13 there were 11 children subject to a child protection plan who are known to the Children with Disabilities Team. This is significantly more than previous years.

Looked after children and care leavers

There are currently 383 looked after children, with 55% placed in borough, either in foster or residential placements, and 41% placed in out of borough placements. (Whereabouts of 4% of the children are not known, usually because they are in adoptive placements or on rare occasions have gone missing from the placement). Given the vulnerability of looked after children and care leavers who are at risk of exploitation and going missing from their placements, the Corporate Parenting Board has taken steps to ensure that the children and young people are safeguarded.

A key priority for the Corporate Parenting Board is the monitoring of compliance with required standards and ensuring looked after children and care leavers are safeguarded. This includes the monitoring of placements both within and out of Hillingdon.

The Board's work plan for 2013-15 has set two objectives that focus on the monitoring and scrutiny of residential and fostering placements. This is achieved through annual reviews of foster carers and statutory reviews for looked after children.

The Access to Resources Team (ART) within Children's Services is responsible for identifying, assessing and monitoring all private and voluntary children's homes, and for recommending a match for the young person. Officers complete a rigorous checklist for all new and change of placement, which includes references, Ofsted inspection reports, staffing details, details of other young people in placement, investigations and complaints. New resources are visited to assess suitability, a checklist and report completed. Existing resources are visited six monthly and any required actions monitored In light of the proposed amendments to the Children's Homes Regulations, the checklist now includes, contacting the local authority in which the home is located, requiring a local area risk assessment.

Elected Members on the Corporate Parenting Board also undertake regular Regulation 33 visits to all the Council's children's homes, adding the extra dimension to inspections. This gives the children and young people the opportunity to raise matters directly that affect them.

Looked after children also have independent access to support services for children and young people in care, which are provided by the National Youth Advocacy Service (NYAS).

Children's Resources Service is responsible for management of London Borough of Hillingdon's Fostering, Adoption & Permanence, Children's Homes (including the Resource service for Disabled Children, Merrifield House) and Placements & Commissioning.

Under the current inspection regime (new inspection regime in place from November 2013), Fostering and Adoption & Permanence are inspected separately every 3 years.

The current inspection has four grades, Inadequate, Satisfactory, Good and Outstanding. These apply to each area of the inspection and there is an overall rating.

In September 2012, the Fostering Service was inspected by Ofsted and awarded a Good judgement. Ofsted noted that "children and young people benefit from stable placements where there are fewer moves between placements than comparable authorities. Managers of the service have developed a good working relationship with other agencies including the police, education and health services to ensure there is a joint approach when assessing and meeting the needs of looked after children"

There were no requirements from this inspection. Recommendations for improvement identified the need to appoint independent visitors to children who have had no contact with family for over 12 months (mainly in relation to

our Unaccompanied Asylum Seeking young people), the need to ensure young people are supported to attend their review meetings, updated information regarding Ofsted contact details in the children's guide and correctly recording the manager's qualification in management. These areas have been addressed.

Hillingdon's Adoption Service was inspected by Ofsted in February 2013 and was judged as Good. Ofsted commended the strength of safeguarding and the leadership and management of the service in their report. It stated that the service is Good at keeping children and young people safe and feeling safe.

There were no requirements from this inspection. Recommendations for improvement identified the need to improve the time taken to find an adopter for a child who has been recognised as being in need of adoption and the time taken to conduct an assessment of adopters. Substantial work has taken place to address this and to bring the service in line with changes in legislation regarding timescales.

The Children's homes are inspected by Ofsted twice a year. There is one full inspection, and one interim shorter inspection that focuses on the action plan from the full inspection. The timescales will not change under the new inspection regime, but the grading will be brought in line with other statutory inspections.

The 3 Children's Homes have all had their full inspections in the first part of 2013, with the interim ones due. They all received a 'good' rating and all requirements and recommendations have been addressed

Young carers

Young carers are children who look after someone in their family who has an illness, a disability, a mental health problem or a substance misuse problem, taking on practical and/or emotional caring responsibilities that would normally be expected of an adult.

A recent report from The Children's Society 'Hidden from View' analyses government data tracking 15,000 children across England. It reveals the long-term impact that caring has on a child's life.

Findings include:

- Young carers are 1½ times more likely to have SEN or a long-standing illness or disability;
- 1 in 12 young carers are caring for more than 15 hours per week;
- Around 1 in 20 miss school because of their caring responsibilities;
- Young carers have significantly lower educational attainment at GCSE level;
- Young carers are more than 1½ times as likely to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language;
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer;

- Young carers aged 16-19 are more likely than the national average to be NEET, and
- Despite improved awareness of the needs of young carers, there is no strong evidence that young carers are any more likely than their peers to come into contact with support agencies.

This is a "safeguarding issue" in its broadest sense and cuts across both the Adults and Children's Safeguarding Boards, as many young carers in Hillingdon are engaged in caring for parents with disabilities and/or recurring mental illness. In March 2013 both Boards received a presentation from Hillingdon Carers.

National estimates indicate 175,000 young carers in the UK and a BBC survey in 1996 estimated that one in 12 secondary school children would be a carer. 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.

687 children have been identified in Hillingdon, of whom approximately 430 at any one time receive services from Hillingdon Carers projects. Increase in numbers identified does indicate greater awareness of the issue. Locally, 53% of young carers are in single parent families and many of these are supporting parents with mental health and/or substance misuse issues. Mental health of a parent forms the largest group overall (47%), followed by a parent with physical or sensory disability (27%) and 23% of Hillingdon's young carers assist with a disabled sibling. Around 10% of young carers identified in Hillingdon are subject to a child protection plan.

In addition to those issues identified by the Children's Society, issues raised locally include

- Bullying, or isolation due to not wanting to disclose caring responsibilities;
- Encouraging those we don't know about to come forward
- How to support young carers who may be aware of an adult at risk but afraid/unwilling to report;
- Preventing teenage carers from becoming abusers.

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.

The Board receives each year the annual returns from the Hillingdon Independent Domestic Violence Advocacy Service (IDVA). Hillingdon IDVA works with people at medium or high risk from domestic violence. The service is managed within social care but based at a local police station in order to facilitate effective day to day working with Community safety Unit. 80% of their referrals are responded to within 24 hours and they work with the victims (mostly women) and other agencies to develop safety plans. These may involve referrals to social care, housing, and may be followed by child

protection, civil or criminal proceedings. Often up to eight services may be involved with the family.

Total referrals for the year were 627, of which 85% engaged with services. 865 children were involved. Many had experienced physical abuse themselves and all would have experienced emotional harm. A significant number were young (16-24) and this number is likely to increase considerably with the recent legislative definitions to include 16-18 year olds. Ethnicity of referrals was roughly comparable with Borough proportions, but 18% of referrals involved cultural issues or honour based violence.

Families at high risk are referred to the monthly MARAC meeting for more intensive safety planning and interventions. MARAC is chaired by the Detective Inspector responsible for the Community Safety Unit and meets monthly. A very wide range of agencies are represented at these meetings, both statutory and voluntary. The meeting shares risk assessments and develops plans for the families. During 2012-13 MARAC looked at 168 cases involving 325 children. Most referrals came from Police or the IDVA service.

The IDVA service provides training in awareness and risk assessment as part of the LSCB training programme and also delivers training in schools. This training continues to achieve highly positive evaluations. They have recently produced a Stay Safe leaflet to support families who have to move away.

The LSCB has expressed concern about the lack of provision to support children and young people who have experienced emotional harm through living with domestic violence. In 2012-13 funding was provided for a local housing association to provide support for children placed in the refuge and for those in the community through workshops**.** Outcome information is not easily available, but anecdotal evidence from staff is that the improved risk assessments and joint communication has greatly improved the safety of many families and children, including development of a child protection plan when appropriate.

Referral to IDVA/MARAC often occurs quite a long time after the precipitating incident of domestic violence so there is a delay in providing services and support. Earlier identification and response therefore remains an issue.

Clearly, much is being done to provide practical resolutions of domestic violence issues. However, it is well known that children who are affected by domestic violence frequently experience long term emotional harm, as evidenced by the numbers who end up in the care or youth offending systems. This was confirmed by NSPCC research which found that young people who witness domestic violence are five times more likely to run away, four times more likely to become violent/carry a weapon, three times more likely to be involved in drugs, crime or anti social behaviour The cost to society and the emotional cost to the young people are clearly high.

The actual or perceived high thresholds for mental health services means that these children do not have access to support services, and support for these children remains a priority for the LSCB and the Children's Trust.

It is also known that those children who experience abuse directly are more likely to become perpetrators themselves. This includes the increased

numbers of teenage perpetrators. The Youth Offending Service includes domestic violence in its work programmes with young offenders

The definition of domestic violence has now been expanded in law to cover more victims.

Young people aged 16 to 17 and coercive control – a pattern of controlling behaviour – is now included in the legal definition for the first time.

The new cross-government definition will raise awareness about the many types of domestic abuse that can ruin lives and encourage more people to seek help.

The Association of Chief Police Officers has commented on the challenges of enforcing the new definition for domestic abuse, but is positive about the change.

Locally a rise in those aged 16-18 experiencing domestic abuse has been noted, so this change is welcomed.

The LSCB plans a case review of referral pathways and responses to domestic violence in early 2014, and availability of training, but current evidence indicates that:

- Response is often late, when the situation becomes very serious. It is hoped that referrals through MASH (when operational) may improve this situation.
- There is a need for more interventions for children and young people, both to support emotional health, and to break the cycle of violence.
- Specific work with adolescent boys is indicated in this context.
- There is a small but significant number of perpetrators who are willing to be helped, if more help and support were available.

Child Abuse Investigation Team (CAIT)

Headline figures from last financial year for Hillingdon:

- 1144 referrals
- 576 crimes - 30.7% detected (charged)
- Serious sexual offences 82 - 57.3% detected
- Rape - 24 / 70.8% detected
- Violence with Injury - 177 20.9% detected

Potential risks to safeguarding

<u>Resources</u>

The lack of sufficient competent and permanent staff continues to pose a risk to safeguarding children. The main risks represented are lack of supervision and management oversight and the impact of a changing staff group on continuity of communication both with other agencies, and with children and their families. It can also lead to unnecessary drift. This issue is most marked in social care, but is also apparent in other agencies, e.g. Police.

Some agencies, due to their wide span, have difficulty in representation on the LSCB, e.g. CAFCASS, Probation, NHS London.

Reorganisation

Virtually every organisation is, or has recently reorganised. This is sometimes due to the need to make savings, sometimes to manage new government requirements, and sometimes to increase the effectiveness of services. These reorganisations create opportunities, but also risks. There are inherent risks in staff losing focus in the midst of change, and some consequential increase in vacancies. There are also potential direct risks to services, e.g. recent changes to Operation Paladin by the Metropolitan Police, which could potentially put at risk some young people arriving at Heathrow, changes in Border Force processes and procedures.

Lack of coordination of early intervention work

This is frequently an issue in case reviews, and results in some children coming to notice too late, often after many years of neglect. This has been addressed by development of the children's pathway programme and the CAMHS review of early intervention services. However, these changes are at time of writing at an early stage.

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.

Inspection and quality assurance

The LSCB has through the year been better able to assess the quality of practice through case reviews and audit. This has been in the main through the appointment of a manager with specific responsibility for quality assurance and audit. However, this needs to be further developed into a fully comprehensive quality assurance framework. There have also been changes in the external inspection regime carried out by Ofsted. The new framework recently introduced will focus very much on Council services for children in need of protection, who are looked after, or who are care leavers. It will include a judgement on the LSCB. However, attempts to create a genuine multi-agency inspection have so far failed, so other agencies will not be adequately represented in the process, and there are concerns whether LSCB can be adequately inspected as a multi-agency partnership under this methodology.

Potential opportunities to improve safeguarding

Staffing

In spite of the concerns raised above, on the whole children are effectively safeguarded in Hillingdon through the efforts of skilled and hard working staff across all agencies. There is much evidence of staff working and communicating well with each other and with children and their families. 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.

There is a strong senior management commitment to safeguarding and a willingness to be held to account by the LSCB.

Reorganisation

The development of the children's pathway programme and key worker system, supported by the shared assessment and referral process, should ensure better identification of the need for early help and coordination of early intervention services. In the long term this should reduce the need for protection, or at least identify much earlier in the child's life, what the risks are, and how they should be addressed.

Signs of Safety

All agencies, through the LSCB, have agreed to implement the Signs of Safety model of assessment. This, by definition, is more involving of families and should be better able to identify child and family strengths, and produce a child protection plan that is clear and achievable for the family. It very much follows the recommendations of the Munro Review

However, this methodology is not as yet fully evidenced in this country, and practitioners will need to continue to challenge families and not be misled into the 'rule of optimism' through a family's apparent cooperation

Inspection and quality assurance

Hillingdon Council is building a culture of continuous quality oversight and improvement based on the inspection standards and this will be augmented by the LSCB quality assurance framework. This work is supported by the appointment of a specialist quality assurance manager, and practice development officer, who has helped to embed the learning from quality assurances processes.

External inspection, although the framework continues to change, does provide some independent external measure of practice.

7. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

Working Together 2013 and London Child Protection procedures

The revised Working Together to Safeguard Children was released in March 2013 and represents a radical shift in the way that the child protection system will operate in England. This includes a new approach to the oversight of serious case reviews, new guidelines for assessing the needs of vulnerable children, and a huge reduction in the level of national child protection guidance.

The new guidance focuses strongly on legislative requirements, and removes large sections of non-statutory practice guidance. In response to consultation, it still includes more detail on the roles and responsibilities of partner agencies such as health and the police. The guidance is clear that "safeguarding is everyone's responsibility" and other headlines include:

- The reinstatement of statutory timescales for assessing the needs of vulnerable children, which had been removed from the consultation documents;
- A removal of the distinction between initial and core assessments, replaced by ongoing, locally developed, assessments of need;
- A change in the governance arrangements for independent Chairs of Local Safeguarding Children Boards (LSCBs), who will now be appointed and held to account by the local authority Chief Executive rather than the Director of Children's Services;
- The establishment of a national panel to hold LSCB Chairs to account on whether serious case reviews should be carried out, which independent reviewers should be commissioned to lead the review, and to challenge any decision that the report should not be published;
- There is a statutory requirement (retained in the new guidance) for a multi-agency serious case review (SCR) to be carried out for every case where abuse or neglect is known or suspected, and either:
    - the child dies, or
    - the child is seriously harmed, and there are concerns about how organisations or professionals worked together to safeguard the child.
- A strong reiteration of the government's intention that all serious case reviews should be published in full, and more detailed guidance on what this means in practice;
- A reversal of the consultation's proposal for all future serious case reviews to be undertaken using so called "systems methodology", with LSCBs instead free to use any model that is broadly in line with stated principles, and
- A requirement on LSCBs to develop a local framework for learning and improvement, including regular reviews of cases that may not meet the

criteria for a full serious case review, as part of an on-going process of learning and development.

Hillingdon LSCB has been reviewing its own local processes to ensure that they are fit for purpose. Multi-agency briefings have been undertaken planned to ensure that practitioners within the Children's workforce are updated and this is aligned to the transformation being driven through the Children's Pathway programme.

London Child Protection Procedures 5th edition

Further to the publication of the revised National Guidance *Working Together 2013,* the London Child Protection Procedures have been rewritten, and were sent round for across all London Boroughs.

The full procedures will be launched at the London Conference in December 2013, and will be discussed and agreed as appropriate at the LSCB in Hillingdon

The Savile case

A high profile investigation during the year involved Jimmy Savile and subsequent revelations.

Her Majesty's Constabulary Inspectorate's' (HMIC) review of allegations made against Jimmy Savile during his lifetime found that mistakes were made by the police and, while policies and practices designed to improve the experience of child victims are now available, the report raises serious concerns over why so many victims felt unable to come forward and report what had happened to the authorities.

To improve understanding of why no specific allegations against Savile were recorded before 2003, HMIC considered policy and practice changes in the Police Service and the wider criminal justice system over Savile's period of offending. HMIC found that a child reporting sexual abuse today is likely to be better treated than 50 years ago. But there is still more to do if children are to receive the full protection of the changes that have been introduced since then.

While this report found only seven records, HMIC has wider concerns about the way the police manage and use information, and whether national guidance is being given full effect in all forces. HMIC will examine this further as part of its review into child sexual abuse and sexual exploitation, which is due to start in summer 2013.

Since the Savile review, the Metropolitan Police in London have decided that the Child Abuse Investigation Teams (CAITS) will have the lead responsibility for investigating child sexual exploitation outside the family home, as it recognized that CAIT officers are more likely to have the skill set and expertise to conduct these investigations. All LSCB chairs/chairmen have been notified of this change. Whilst welcoming this in principle, it is not yet clear whether this will result in additional capacity being built into the CAIT teams, and our local police colleagues have expressed some concern over this, as it is not yet clear what the levels of additional demand will be. The LSCB will be monitoring this carefully.

Government response to Lord Carlile's report on the Edlington case

In March 2012, the Secretary of State for Education, asked Lord Carlile to conduct an independent review of the case of the 'J' children in Edlington. The 'J' children had committed a very serious assault on 2 young victims in April 2009, having assaulted another young victim the previous weekend.

Doncaster LSCB commissioned a Serious Case Review and published the executive summary in January 2010. The purpose of Lord Carlile's further review was to look at the issues raised by the case and action taken in response locally, and also to consider where there may be a need for improvements more widely in the child protection system.

This document, published in January 2013, is the formal response to Lord Carlile's report on the Edlington case. It is intended to prompt further debate and discussion of the challenges he sets for LAs and central Government.

Children's services have considered this document carefully in the process of completing the strategic plans for Hillingdon children's services, in alignment with the Children's Pathway Programme. For example, the Government's expectation of robust and swift early intervention to safeguard children may mean more children being taken into care, especially when the parents are unable to change sufficiently to meet their children's needs.

The number of care proceedings in Hillingdon is continuing to show an upward trend, which will put pressure on the 26 week timescale for completion of care proceedings, envisaged by the Family Justice Court review. This is in line with a national picture which shows an increase in care proceedings since Baby Peter. In order to test this further and drive up the standards, Hillingdon children's services has joined up to the West London care proceedings pilot, which will have the benefits of improving social work assessments, thus negating the need for reliance on external experts.

Children who experience neglect

<u>Neglect and serious case reviews</u>

The NSPCC and the University of East Anglia have published (11/03/13) a systematic analysis of neglect in serious case reviews in England between 2003 and 2011. Findings include the fact that 59% of children known to social services who died or were seriously injured had been on a child protection plan for neglect at some point in their lives.

Recommendations include: an expert social worker in every local authority to advise on child neglect cases.

The Children's services, social care transformation programme, allows for the recruitment of Advanced practitioners who will have expertise in this kind of research. Researched and informed practice will then be integrated into the "PODs" being developed and piloted through the Children's Pathway programme.

Also a précis of this research has been uploaded onto Hillingdon's Social Work research web page which is currently being built on Horizon.

SPCC report “How safe are our children?”

This report, issued by the NSPCC at the beginning of April 2013, compiles up-to-date child protection data that exists across each of the four nations in the UK. It sets out 19 different indicators and each indicator looks at the question from a different perspective. These indicators will be regularly updated as new statistics are published.

The report allows us not only to understand how many children are being abused and neglected, but also to track progress so that society can be held to account for its responsibility to children. Only by monitoring the extent of child abuse and neglect in the UK can we judge whether efforts to prevent maltreatment and to protect children are actually working.

A summary of the NSPCC report has been disseminated to practitioners via the Local Safeguarding Children Board (LSCB) Training and Development Manager, and the research will be fed into the action learning sets, which will be rolled out over the next few months to support our local reflective supervision programme, as it is bedded into practice.

Neglect is a critical issue. A large percentage of children with a child protection plan have experienced neglect (42% of children on CP plans in Hillingdon are under the category of neglect). Long term neglect is a feature in the lives of many adolescents who come to notice, often through criminal behaviour. But, as can be seen from some national cases, this behaviour masks vulnerabilities that can be exploited by criminals or paedophiles.

“Always Someone Else’s Problem"- Office of the Children’s Commissioner’s Report on illegal exclusions

The Children’s Commissioner’s report provides quantitative evidence from teachers and school leaders about the scale and nature of illegal exclusions from schools in England. This practice, as far as it can be measured, appears to affect a small but significant minority of schools, and therefore pupils.

The Children’s Commissioner found evidence of:

- pupils being excluded without proper procedures being followed; these exclusions are usually for short periods, but may be frequently repeated, meaning that the child misses substantial amounts of education;
- pupils being placed on extended study leave, on part time timetables, or at inappropriate alternative provision, as a way of removing them from school;
- pupils being coerced into leaving their current school, either to move to another school or to be educated at home, under threat of permanent exclusion;
- schools failing to have due regard to their legal responsibilities regarding the exclusion of children with statements of SEN or Looked After Children;
- schools failing to have due regard to their responsibilities under the Equality Act 2010, and

- LAs failing to deliver their legal responsibility to provide full time alternative education for children from the sixth day of exclusion.

This is an issue which had already been picked up by the Local Authority Officers within Hillingdon, and had been incorporated into a recent report by the Education and Children's services Policy Overview Committee, (POC) in which a number of key recommendations have been made to help address this concern.

Parents with mental health problems

What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems.

Ofsted and the Care Quality Commission (CQC) have called on the government to make it a mandatory requirement for mental health services to collect data on children whose parents or carers have mental health difficulties and report on such data nationally. (25-04-2013). The recommendation is contained in a joint survey which highlights how the lack of identification of children living with parents with mental ill health has led to them not receiving the help they need, with some being left at risk of harm.

Currently, it is a mandatory requirement for adult services to gather information about children and report to the National Treatment Agency for Substance Abuse where their parents have drugs/and or alcohol problems. However, this is not the case for children whose parents have serious mental health difficulties.

In Hillingdon, a joint protocol is being drawn up between Children's social care and adult service to make sure that there is a more integrated, and holistic approach to working with families, where parents have enduring mental health issues, or even mild conditions which may impact on the well-being of children.

National Health Service

Clinical Commissioning Group (CCG)

The CCG began operating officially in March 2013. This is the body responsible for most Health commissioning in the area. (Some specialist services will be commissioned by a national body – NHS England)

The designated nurse and doctor for safeguarding now work to the CCG which has lead representatives on both the Children and Adult Safeguarding Boards. They continue to sit on the LSCB.

The Director of Public Health (DPH) is now based in the local authority, and all local authorities now have the lead for public health assessment and planning in their area.

The DPH, representatives from the CCG, sit on the LSCB and the LSCB report will also be presented to the Health and Wellbeing Board.

Local Developments

Children's Pathway Programme

Building on the good work achieved through the Family Intervention Programme the Children's Pathway Programme has been looking at children's services across the Children's Pathway in both Education and Children and Family Services, following the journey of the child through the system across all levels of need.

This work culminated in a transformed structure, which integrates early intervention services in schools and Children's centres, through to Children's social care. A new top level organizational structure has been agreed to embed this integration.

A number of work streams have been developed, which have included a number of pilots around better ways of working with families. These include "keyworking" services in tiers 1 and 2, and "POD" working in statutory services. The Children's Pathway Programme is continuing to drive all the changes mentioned below:

Single Holistic Assessment

Working Together 2013, has relaxed the requirement to have an initial assessment of need (10 working days) and a Core assessment (35 working days), with greater emphasis on the need for professionals to apply their judgment about need, and to problem solve and intervene with families at the earliest opportunity, in the most timely way for the child. The Children's Pathway Programme had already sponsored and anticipated this more effective way of working through piloting a single holistic assessment during the early part of this year. The evaluation showed some positive outcomes for children and better quality communication with other agencies. From May 1st 2013, the single holistic assessment went fully live across the social work teams in the Mezzanine offices, and is now being piloted within the Children in Care teams and Leaving Care Teams, which are also being restructured.

Early Help Assessment and multi-agency referral form

It was generally agreed that the common assessment framework (CAF) had not been used most effectively and had been deployed mainly as a referral to social care. The CAF has now been replaced by a shared family Early Help Assessment which will be used in early help services to develop the assessment and planning though the team around the Family and key working processes.

Alongside that, a referral form has been developed to clarify the reasons for referral to social care.

Both of these were developed by practitioners across agencies and piloted prior to full roll out in summer 2013.

It is hoped that the multi-agency referral form can be further developed and used for referring to all specialist services, e.g. CAMHS.

Signs of Safety (SOS)

The Signs of Safety is a model for working with families, based on systemic theory and principles. This approach has been adopted by a number of local authorities, both across London and nationally, to enable a stronger focus on early intervention and promoting better outcomes for children. The Signs of Safety Model has grown from researched and informed practice in Western Australia and more latterly is becoming widespread in the UK, and other parts of Europe.

The Signs of Safety approach is a practical framework, aimed at equipping practitioners with the techniques they need to elicit partnership working with children and families, who are involved in the child welfare system.

The Model draws on the language and tenets of brief solution focused therapy. This is a 'client centred approach' developed by Steve de Shazer et al (1985). It operates on the premise that, even in the face of difficulty, the 'family' is already in possession of resources, which if supported, can be mobilised to elicit positive changes in their circumstances. Contrary to the traditional approaches to risk, which tend to focus on the deficits of a client's circumstances, the Signs of Safety model looks at the existing strengths, and potential safety capacity, for children to thrive within their own family context.

The use of this approach has been endorsed by partner agencies across the LSCB, and is being integrated into the Children's Pathway Programme, as it will help to improve outcomes for Hillingdon's vulnerable children and families. A project steering group has been set up 2013, to drive the implementation of Signs of Safety reporting into the Director for Children's Services.

An external trainer, an expert in Signs of Safety, has been deployed to run some of the formal training sessions, in order to accredit local officers and designated professionals, who will become trained as specialists in Signs of Safety in Hillingdon. Some LSCB and Children's Trust Board Members have also been briefed in the techniques of Signs of Safety.

Further training will be rolled out for practitioners through briefings and action learning sets, so that the application of the techniques of Signs of Safety is properly learnt and understood across all agencies at all levels. This will be delivered via the LSCB multi-agency training programme.

The Signs of Safety will be incorporated into the Business Plans of the LSCB and Children's trust as well as PADA training objectives, as part of the continued professional development of social workers, teachers, Health visitors etc and their managers.

Key Operational Managers, Professionals and Designated/Named Professionals within each agency (designated teachers, nurses etc.) will be expected to lead the changes in practice. They will receive bespoke training to enable the model to be embedded in practice throughout the system, across all the levels of need, within Hillingdon's Operating Model.

Multi-Agency Safeguarding Hub (MASH)

The MASH model is a national multi-agency initiative to provide information sharing arrangements across all agencies involved in safeguarding children.

Those involved are employed by their respective agency e.g. police, health and local authority, and located in one office.

The MASH model is intended to provide information that is already known within separate organisations in a coherent format that enables “real time” effective and appropriate response to concerns or referrals received by the MASH.

The principles of MASH are consistent with the recommendations in the Laming Report (2009), Munro review of Child Protection (2011) and Serious Case Reviews, where inconsistent, un-coordinated information exchange has had a detrimental impact on safeguarding functions.

The MASH model is regarded as best practice for managing the information flow between agencies to strengthen safeguarding practice. The London Safeguarding Board is fully supportive of the model and the Metropolitan Police Service has made a significant financial commitment to implement MASH across the London Boroughs.

Hillingdon’s Approach to MASH

Hillingdon have signed up to developing the MASH model at the point of referral within Children’s Social Care. Hillingdon have further committed to managing Adult Safeguarding referrals using the MASH model. In doing so they would be one of the first London Borough to achieve this duel role.

Progress so far

A MASH Operational Delivery Group has been set up and taken responsibility to deliver Hillingdon’s MASH in autumn 2013. The group includes representatives of all the key agencies involved in safeguarding. Each of the agencies has committed to be part of the MASH:

- Children and Families Social Care
- Adult Safeguarding
- Local and Regional Metropolitan Police
- Community Health and Health Commissioning
- Probation
- Education
- Housing

The operational group is currently assessing what level of commitment each partner needs to ensure the success of the MASH.

Delivering MASH

There are several key strands of work underway to ensure MASH is ready to be implemented in autumn 2013.

To date there has been significant enthusiasm for this Project across all agencies, despite the tight timescales and resource implications. There is a genuine professional belief that working together to safeguard Hillingdon’s children within the MASH will produce positive outcomes for vulnerable children.

Education changes

The main emphasis of Government education policy is an increase in the independence of schools and the consequential reduction in the influence of the local authority. There are therefore potential risks to safeguarding both in terms of the monitoring of individual schools and the lack of consistency in external commissioning of support services

In Hillingdon, although most secondary schools are now academies, all schools have remained fully engaged with the LSCB. This will be supported through the further development of safeguarding clusters across the Borough.

8. WHAT WE NEED TO DO: priorities for LSCB 2013 onwards

Our evaluation of the progress against our priorities plus our assessment of the effectiveness of local safeguarding arrangements, consideration of relevant national issues and feedback from staff have led us to identify the main priorities for the Board's work from 2013.

N.B. The LSCB is now required to influence and assess the development of early intervention services, as these are critical in improving the safeguarding of children, and in ensuring that only those in highest need receive social care services. The LSCB will also monitor the interfaces between preventative and statutory services to ensure that thresholds are clear and consistent. However, it is important that The LSCB continues to keep as a main priority those children and young people who are most at risk of harm, i.e. those who come into the social care system in need of protection.

We have a challenging work plan, but, whilst all require attention, the Board has decided that particular priority should be given to:

- Oversight of the early help assessment and plans, and alignment of pan London levels of need with thresholds with early help and social care services.
- Developing the community voice within the LSCB by better understanding of the child's view and making effective use of our lay members.
- Getting a better understanding of domestic violence pathways in order to identify earlier and ensure that the most effective interventions are in place.
- Further improving our quality assurance processes so we have a clear window on local practice and systems.

Priority 1 Improve LSCB functioning

- Roll out implementation and training for Working Together 2013 and London procedures
- Improve LSCB scrutiny of early help services
- Implement Multi-Agency Safeguarding Hub
- Implement Signs of Safety approach to child protection
- Improve engagement with, and involvement of children and young people
- Improve engagement with staff across all agencies
- Establish effective engagement with new health agencies, and the Health and Wellbeing Board.

Priority 2 Assess and improve operational practice

- Embed revised threshold criteria across all levels of need
- Embed early help shared assessment and single holistic assessment process in line with revised Government guidance

- Further develop and improve learning from multi-agency audit process.

Priority 3 Improve outcomes for children affected by key risk issues

- Continue to develop and improve practice in respect of children newly arrived, those who go missing and are at risk from sexual exploitation and gang activity
- Review services to those affected by domestic violence
- Oversee development of CAMHS tier 2 services.

Priority 4 Ensure a safe workforce

- Continue a full multi-agency training programme that meets needs of agencies
- Roll out training programme for Working Together 2013 and London procedures
- Further develop the LADO training to include faith and community groups.

Priority 5 Learn from Case Reviews

- Continue to learn from cases and meet the requirements of chapter 4 of Working Together 2013
- Continue to implement learning from unexpected child deaths and disseminate key messages to local professionals –translate information on safe sleeping into relevant languages.

Individual agency plans

YOS key plans for 2013-14:

- With partners, review multi-agency work with children and young people who sexually offend, against the good practice and recommendations contained within the HMIP Inspection report published in February 2013.
- Implement pre-court disposals (as of April 2013), monitor and review process and interventions.
- Review existing practice for children and young people placed away from home who offend, against the good practice and recommendations contained within the HMIP Inspection report published in December 2012.

Voluntary Sector

- In 2013/14 HAVS will continue to update voluntary agencies, and in particular the introduction of the DBS update service and the roll out of the new shared assessment.
- In addition, some of the boroughs mosques and madrasahs will be supported for the first time to understand their responsibilities to implement 'Working Together' and develop quality policies and practice in safeguarding. Training is planned for mosque and madrasah staff and volunteers.

Early years Key plans for 2013-14:

- To ensure settings and practitioners are better informed in relation to keeping children safe. This will be achieved through 20 additional setting managers have accessed the “working together” training and 20 settings have accessed domestic violence training.
- To support practitioners in gaining a deeper understanding of “low level” child abuse. This will be achieved through supporting 90% of settings to implement an effective supervision structure that enables staff to share all concerns in relation to the safeguarding of children. Training, advice and support will also be provided.

CNWL HCH Priorities for 2013-2014:

- The named professionals will use training and supervision sessions to ensure the workforce are aware of the key changes contained in the revised statutory guidance Working Together to Safeguard Children (2013).
- The named professionals have responded to the London Safeguarding Children Board editorial group request for comments on the draft version of the London Child Protection Procedures. The safeguarding children team will provide a link to the guidelines when they are launched.
- Work in partnership with the local authority in order to identify and safeguard children at risk of sexual exploitation. Ensure HCH staff are aware of how potential or actual victims may present and what the local arrangements are.
- HCH will revise the mandatory safeguarding children training programme to increase compliance levels whilst maintaining adherence to the intercollegiate document. Develop a dashboard system to collect child protection activity data.
- Ensure children’s services staff and the HCH Safeguarding Group receive feedback from the 8 cases that were audited as part of the preparation for the peer review. The named nurses will participate in 2 further multi-agency audits in 2013 as part of the remit of the Risk Management Panel.
- Re write the record keeping audit tool to collect qualitative data in order to assess the recording of children’s views. This audit will be undertaken in January 2014. The named nurses will continue to support staff develop their skills in this area.
- Embed the Signs of Safety model and support staff attending the new style of case conference. Develop and roll out a new template for case conference contributions from health staff in line with the new signs of safety case conference format.
- The named nurses will provide support and supervision to the nominated health professional allocated to the Multi-Agency Safeguarding Hub (MASH).

CNWL Mental health services plans for 2012-13

- The “think family” agenda is a huge issue for adult services and one where there is much to learn from CAMHS colleagues. There are impacts of hidden harm that the services need to identify consistently. To address this, the Trust has established a project in Spring 2013 to promote “think family” as part of service delivery in service lines.
- Mental health services are moving to payment by results as its major funding source from 2014/15. This means 2013/14 will be a shadow year for these changes. The Trust is carefully monitoring the impact of changing service delivery into service lines and would welcome partner agencies views on any unforeseen impacts.
- CAMHS, like other service lines, have plans to complete service redesign/ improvement work. This will include developing groups across the service with children, young people and their carers and other stakeholders to test out our ideas on service planning and redesign.
- The Trust will be looking to tender the software packages used and it is hoped that this will allow the opportunity to resolve some of these data issues.
- CNWL may apply for Children and Young People IAPT, which embeds a CBT model of service delivery with extensive outcome evaluations using a range of measures. Other Boroughs are currently doing the training and the learning may be rolled out to Hillingdon staff in the next year.

9. CONCLUSIONS AND RECOMMENDATIONS TO THE CHILDREN'S TRUST AND OTHER BODIES

Our overall assessment of safeguarding in Hillingdon is a cautious 'good'.

We see evidence of sound practice and effective multi-agency communication and collaboration at the front line. Operational practice in respect of children at risk through going missing or trafficking is sound and nationally and internationally recognised. Work around understanding child deaths and in managing staff allegations is strong and there is an effective multi-agency training programme

Once a crisis has occurred families and children on the whole seem to receive effective help and appropriate actions are taken.

Changes and developments within children's pathway services should ensure, on one hand, improved supervision and management oversight, and also better identification and support through early help services

Potentially these strengths could be put at risk through staff shortages and lack of management vigilance and oversight. It is noted that the Council is putting considerable effort and resource into staff recruitment and this is welcomed.

There has been no reduction in the impact of some of the more intractable problems, such as domestic violence, mental health, and long term neglect – often not picked up until adolescence. Children at risk of trafficking and/or exploitation will always require continued vigilance, particularly in the context of Heathrow.

It is vital therefore that early help services are effective in picking up these issues early and coordinating best action to support and avoid duplication. It is also vital that best use is made of early intervention services to support families and prevent escalation of problems. In times of financial constraint, reduction in support services is a false economy, but services should be carefully targeted. Shortage of CAMHS early support services remains a concern.

Changes in partner organisations continue into 2013-14. Issues such as CAFCASS changes, the new Probation model, changes in Health services, and Metropolitan Police changes (e.g. Paladin) impact heavily on staff morale and multi-agency working. These changes have also impacted on involvement at a strategic level on the LSCB. However, the local Clinical Commissioning Group (CCG) is now well represented going into 2013-14.

One of the clearest messages coming out of local and national case reviews and research is the vital importance of staff communicating clearly with each other, preferably face to face, but also though more effective IT systems. This is the whole basis of core groups, Team Around the Child etc. Although many changes are unavoidable in the current climate, communication and information exchange must remain a priority.

Some reorganisation and review mean that some agencies and services are not yet mature, e.g. Clinical Commissioning Group, Early Help services and CAMHS tier 2. This will hopefully be addressed during 2013-14.

APPENDIX 1: LSCB membership

Chairman and officers of the LSCB

- Lynda Crellin - Chairman (Independent)
- Maria O'Brien – Deputy Chairman, Managing Director, Provider Services, Hillingdon PCT
- 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
- Joseph Matia - LSCB Legal Advisor
- Julie Gosling - LSCB Administrator

Observers

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

Local authority representatives

- Merlin Joseph - Deputy Director, Children & Families, Social Care, Health & Housing
- Pauline Nixon - Interim Chief Education Officer
- Lynn Hawes - Service Manager, Youth Offending Service, Social Care, Health & Housing
- Nick Ellender - Service Manager, Safeguarding Adults, Social Care, Health & Housing
- Pauline Moore - HR

Health representatives

- Maria O'Brien - Managing Director, Provider Services, Hillingdon PCT
- Sharon Daye - 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

Police and probation representatives

- Richard Turner - Detective Chief Inspector, Hillingdon Borough Police
- Paul Monk - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police
- Paul Brannahan - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
- Marcia Whyte – Senior Probation Officer, London Probation

School representatives

- Sue Pryor - Head teacher, Swakeleys School/Kim Rowe – Head teacher, Bishopshalt School
- Catherine Moss - Head teacher, St Bernadette's School
- Representative for special schools – not in post

Other representatives

- Gavin Hughes - Deputy Principal Officer - Uxbridge College
- Rose Alphonse - Uxbridge College Children's Centre
- Fiona Millar – Children, Youth and Family Manager, HAVS
- Danielle Lambert – Regional Director, UKBA
- Chris Condon – Projects Officer

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
CSE	Child Sexual Exploitation
CNWL	Central and North West London Trust
CIN	Children in Need (sec 17 Children Act)
CP	Child Protection
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
HMIP	Her Majesty's Inspector of Prisons
ICT	Information and Communication Technology
IDVA	Independent Domestic Violence Advocate
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Analysis
LADO	Local Authority Designated Officer (allegations against staff)
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
LSP	Local Strategic Partnership

MASH Multi-Agency Safeguarding Hub

NSPCC National Society for Prevention of Cruelty to Children

NPIA National Policing Improvement Agency

PIP Partnership Improvement Plan

POC Policy Overview Committee

PCT Primary Care Trust

PEECS Planning, Environmental, Education Community Services

SAPB Safer Adults Partnership Board

SCIE Social Care Institute for Excellence

SCR Serious Case Review

SEN Special Educational Need

SIT Safeguarding Improvement Team (NHS London)

SOS Signs of Safety

THH The Hillingdon Hospital

YOS Youth Offending Service

UKBA United Kingdom Border Agency

APPENDIX 3: LSCB Budget

Income 2012-13

Health	60,000
Local Authority	61,250
Metropolitan Police	5,000
UK Border Agency	5,000
Probation	2,000
CAFCASS	565
Government Grant (Munro funding)	38,000
TOTAL	171,815

Outgoings 2012-13

Staffing	92,000
LSCB Chairman	22,000
Consultancy (PIP management & website)	7,000
Independent reviewer (SCIE Pilot)	7,500
e-Learning training licence	7,000
Office running costs (stationery/telephone etc)	4,500
Catering – LSCB conference	5,000
TOTAL	144,500

The balance of £26,315 has been rolled over to the current financial year (2013-2014) to pay for Independent multi-agency case reviews and development of Signs of Safety.