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A

Education & Children's Services Policy Overview Committee

Date: **WEDNESDAY, 23 NOVEMBER 2011**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

Councillors on the Committee

Catherine Dann (Chairman)
Judith Cooper (Vice-Chairman)
Peter Curling, Labour Lead
David Benson
Lindsay Bliss
John Hensley
Susan O'Brien
John Riley

Other Voting Representatives
Anthony Little, Roman Catholic Diocesan.

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Policy Overview

About this Committee

This Policy Overview Committee (POC) will undertake reviews in the areas covered by Education and Children's Services Group and can establish a working party (with another POC if desired) to undertake reviews if, for example, a topic is cross-cutting.

This Policy Overview Committee will consider performance reports and comment on budget and service plan proposals for the Education and Children's Services Group.

The Cabinet Forward Plan is a standing item on the Committee's agenda.

The Committee will not consider call-ins of Executive decisions or investigate individual complaints about the Council's services.

Terms of Reference

To perform the policy overview role outlined above in relation to the following matters:

1. All of the functions of the Council as an education authority under the Education Acts, School Standards and Framework Act 1998 and all other relevant legislation in force from time to time;

2.Pre-School and the Council's work with the Early Years Development and Childcare Partnership

3. The Youth Service and the Council's work with the Connexions Service and Partnership;

4. Social Care Services for Children, Young Persons, and Children with Special Needs.

Agenda

1	Apologies for Absence	
2	Declarations of Interest in matters coming before this meeting.	
3	To confirm that all items marked Part 1 will be considered in Public and all Part 2 items will be considered in Private	
4	Matters that have been notified in advance or urgent	
5	To receive the minutes of the previous meeting.	1-8
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Minutes

EDUCATION & CHILDREN'S SERVICES POLICY OVERVIEW COMMITTEE

19 October 2011

Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Catherine Dann (Chairman) Judith Cooper (Vice-Chairman) Lindsay Bliss Peter Curling John Hensley Susan O'Brien John Riley Wayne Bridges **Representative** Tony Little - Roman Catholic Diocese **Witnesses Present**: Jane Lowe - Home Education Advisory Service Michelle Connolly, Theresa Deng, Zoe Harland & Patrick Ansah– Parents **LBH Officers Present**: Anna Crispin - Chief Education Officer, Merlin Joseph – Deputy Director, Children & Families, Deborah Bell – Service Manager, Special Educational Needs, Behaviour & Attendance & Pupil Support Teachers, Pauline Nixon – Head of Access and Inclusion and Nadia Williams – Democratic Services Officer	
32.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies had been received from Councillor David Benson. Councillor Wayne Bridges attended in his place.	
33.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING.** *(Agenda Item 2)* Councillor Catherine Dann declared a general Personal Interest as she was a Governor of Newham Junior School and Bishop Ramsay C of E School. She remained in the room during the meeting and took part in the discussion. Councillor Judith Cooper declared a general Personal Interest as she was a Governor of Charville & St Andrews Schools. She remained in the room during the meeting and took part in the discussion. Councillor Susan O'Brien declared a general Personal Interest as she was a Governor at Sacred Heart Roman Catholic School. She remained in the room during the meeting and took part in the	

	discussion. Councillor Wayne Bridges declared general Personal Interest as he was a Governor of Uxbridge High School. He remained in the room during the meeting and took part in the discussion. Councillor John Riley declared a general Personal Interest as he was a Governor of Field End Infant School. He remained in the room during the meeting and took part in the discussion. Councillor Peter Curling declared a general Personal Interest as he was a Governor of Mellow Lane School and Harefield Academy. He remained in the room during the meeting and took part in the discussion. Councillor Lindsay Bliss declared a general Personal Interest as she was a Governor of Brookside Primary School. She remained in the room during the meeting and took part in the discussion. Tony Little declared a general Personal Interest as he was a Governor at Pinkwell & Harlington School. He remained in the room during the meeting and took part in the discussion.	
34.	**TO CONFIRM THAT ALL ITEMS MARKED PART 1 WILL BE CONSIDERED IN PUBLIC AND ALL PART 2 ITEMS WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 3)* It was confirmed that all items would be considered in public.	
35.	**MATTERS THAT HAVE BEEN NOTIFIED IN ADVANCE OR URGENT** *(Agenda Item 4)* There had been no matters notified as urgent.	
36.	**TO RECEIVE THE MINUTES OF THE PREVIOUS MEETING.** *(Agenda Item 5)* The minutes of the meeting held on 7 September 2011 were agreed as a correct record and signed by the Chairmen, subject to Minute 29 First Major Witness Session 1 (first bullet point) being amended to note "the Education Act 1996" and not 1966 as stated.	**Action by** Nadia Williams
37.	**REVIEW RECOMMENDATION UPDATE - INCLUSION STRATEGY** *(Agenda Item 6)* Officers gave an update on the Inclusion Strategy which had been marked as 'to follow 'on the agenda and had been circulated to Members prior to the meeting. Officers drew the Committee's attention to note that there had been many changes to schools since the recommendations on the Strategy following the Committee's Review in 2009. There had also been a requirement to change the format over the last few years, as the targets set in 2009 were to have been delivered by the schools and could not be achieved by officers.	**Action by**

	It was explained that strategic action groups had been set up to look at the new format of the Strategy, which had been linked together with the primary Schools Inclusion Strategy. The focus now had shifted to what was a priority for the Local Authority (LA) rather than the work in schools, particularly as the LA now had less influence in schools. The Committee heard that the Progress Update on Inclusion Strategy, as at October 2011 had been best fitted to the recommendations as far as possible. It was highlighted that as the Academy programme was continuing to progress as schools became autonomous, many targets in the Inclusion Strategy would be based on the ability of the LA to influence practices in schools. During discussion, the following points were noted: • The schools were responsible for SEN - the LA became responsible once there was a requirement for a Statutory Assessment (where a child was "Statemented"). • The LA had a responsibility to provide "Parent Partnership" to give advice to parents in respect of SEN and the LA also had a responsibility to provide Education Psychology Services to support the identification of SEN. • Schools were very secure in their knowledge of SEN and valued the support from the Council's School Improvement Officer. This process had proved very successful prior to schools opting for academy status. • That it was possible for schools with an academy status to not communicate with the LA if they so wished. • Ultimately, there was a responsibility placed on schools and would be judged through their regulatory bodies which examined processes (The Office for Standard in Education, Children's Services & Skills (Ofsted)). • The LA's views would be taken into account in respect of schools in "special measures" • The Admissions process remained the same for children with SEN (Statemented). • Although no outcomes had been set out in the Inclusion Strategy update, it was noted that outcomes for SEN in Hillingdon remained higher than for children in other local authorities. This data had been circulated as part of the Annual Standard Quality in Education report, which was reported at the meeting in February 2011. • That there had recently been a significant increase in the number of children coming into the Borough, which had resulted in all special schools taking well over their required numbers. • Children were still being sent out of the Borough and there was no option but to use non-maintained schools. • The increase had come about as a result of high numbers of children coming from abroad, as well as from across London (which may have been influenced by the cap on housing). This increase did not include the young children coming through the system (which the LA was aware of and had planned for) and were different to the 'in year' mobility group as described above.	Anna Crispin

	• It was stated that the LA had a duty to provide places for SEN children either within the Borough or outside the Borugh. **Resolved – That the report be noted.**	
38.	**SECOND WITNESS SESSION - ELECTIVE HOME EDUCATION** *(Agenda Item 7)* The Chairman welcomed the witnesses for attending the meeting to give their views and experiences of Elective Home Education. Michelle Connolly, Theresa Deng, Zoe Harland and Patrick Ansah who were parents and Jane Lowe from the Home Education Advisory Service (HEAS) provided the review with the following information: • Educating the children at home had led to a positive experience for the children and positive development of the children. It had also enabled parents to impress their ethos and morals on their children. • Preferred this way of educating their children as they saw how the children thrived and developed a thirst for learning. • Suggested that there was no official line of informing the LA on issues. • Staff in Education had little knowledge of Home Education. • The only available support was through a Home Education Network Group, where parents met to do different activities together such as swimming and craft. • Experienced negativity by unannounced visits from the LA. Considered that such visits appeared to cast a feeling of suspicion over families who chose to educate their children at home. • Felt strongly that if a parent decided to home educate, this should not automatically present safeguarding issues in terms of the need for the involvement of Social Services. • Did not consider that by allowing home visits, this would necessarily safeguard children. • Strongly believed that according to the law relating to EHE, families were not legally obliged to engage with the LA. • Considered that the Local Authority's Policy had been tweaked to suit the Council's position, as oppose to that stated in law. • Perturbed by letters received threatening that if parents did not respond to the letters, the children would be taken and placed into schools. • Had even received a call at work to be informed that the LA wanted to make a home visit. • Had been asked to put children's names on the Local Authority's register of children whose parents had elected to educate them at home. • Suggested that an antagonistic approach would not promote a positive relationship between the LA and parents. • Stated that the LA did not appear to appreciate that a great deal of effort went into preparing the children for the Curriculum. • Suggested that there was a need for roles to be clearly set out	**Action by**

to enable open relationship between EHE parents and the LA.

- Announced that the HEAS, a National Registered Charity provided practical and legal support to HE parents and were aware that there were families who caused concerns. Suggested that families who gave cause for concern were usually well known from the earliest position.
- Suggested that the LA had the tools to intervene when there were problems in the care of children, as families were in receipt of services from different areas.
- Felt that all EHE families should not be viewed with suspicion.
- Indicated that there were a number of families home educating their children who did not want to be told what they should or should not teach.
- A parent suggested that they had had four visits in the four years of home educating their children and found the officers to be very polite but felt that the officers were not interested in what they taught but were more interested as to whether the children were healthy.
- Advised that parents were not being given practical support or advice and felt that instead, officers were checking up on them. This approach did not give parents any incentive to come forward.
- Suggested that support like providing a list of schools where children were able to take exams would be helpful and would lead to better rapport with the LA.
- Felt that more parents would be interested in working with the LA if they were provided with useful information.
- A parent mentioned that they had had a positive relationship with the EHE Adviser and had never refused a request for an inspection, due to the approach and helpfulness of the adviser that had visited them. This positive experience had led her to encourage another EHE parent who was not known to the Authority to register, so that she too could be visited.
- Advised that since the officer retired, the helpful advice and report on the progress of the children had ended. She then received a threatening letter after a number of years, and suggested that had the family's files been examined, it would have been seen that she had complied with the visits in past years.
- Advised that EHE parents were not obliged to register with the LA and the law did not imply that the LA must ensure education was taking place, nor did it mean that the LA could intervene in the lives of every individual child.
- Suggested that Section 9 of Education Act 1996 (page 13) of the agenda was irrelevant as, there was no situation any where in the law which justified intervention with every family. Felt that the paraphrase obscured and added to the confusion.
- Advised that some local authorities where parents' views were respected, had an informal get together which did build relationships.
- That parents who elected to home educate, retained the duty to educate their children and did not receive public money.

During discussion, the following points were raised by Members:

- The role of the LA was needed to be clearly stated, so that parents knew what their expectations were.
- The receipt of threatening letters would create barriers between the LA and parents.
- The LA needed to make it clear as to what home educating parents should expect and not make the parents feel that if they did not comply with what was required, they would be legally forced to do so.
- Asked officers what systems and processes had been in place prior to 2009?
- Stated the LA would wish to maintain the National ruling relating to unannounced visits.
- Noted that the feelings of parents were that the LA was not taking a risk management approach to safeguarding issues.
- Pointed out that the tone of follow-up correspondences to parents needed some attention.
- Highlighted that offering help and practical solutions was more likely to encourage parents to contact the LA.
- Having ascertained that EHE parents would welcome a degree of relationship with the LA, noted the Policy offered the prospects of developing that relationship, as well as the potential for any family to let the LA know what support they would like to receive.
- Encouraged by parents present that they would welcome the proposed annual get together for EHE parents to meet with the LA and raise any issues they may have. It was considered that this may even encourage those families who did not want to be known to become interested.
- Noted that schools had unannounced visits by OFSTED and parents who elected to home educate retained that responsibility.
- Noted that the LA should endeavour to work in partnership with EHE parents by developing good relationship with families and strive to change the perception of being suspicious.

Officers responded to points raised as follows:

- That systems and processes had not changed since 2009 when Legal Services and Local Safeguarding Children's Board approved them.
- A letter was sent by the LA annually to parents instructing them to take up the offer of (registering their children) if they so wished.
- Acknowledged that the parents present represented those parents who educated their children with care and concern. It was pointed out however; that there were families who home educated their children who did not have the same care and concern.
- Indicated that there needed to be some clarity between the Children's Act 2004 and the Education Act1996.
- Advised that the current position was that of the 91 known

	children that were Home Educated, 8 had not been seen in the community in any situation including by General Practitioners (GP) for over 12 months. • Stated that it was regrettable that some parents had felt the LA's approach had been threatening, and emphasised that it was the minority of parents in the Borough that were of the concern to the Council. • Advised that systems and processes had been in place since 2001 and that the LA's Policy came into effect in 2009. • Pointed out that the Education Department was separate from Social Care, and from the Education Law perspective, officers were charged to take reasonable steps to ensure the safety of a child. The systems and processes currently in place was considered to be a reasonable step in trying to move towards ensuring a child's safety. • Letters to parents would be reviewed by the Parent Partnership Service to ensure that they were appropriately phrased. • The Pupil Referral Unit had taken candidates for GCSEs in the past and there were plans to offer this service to EHE families in Hillingdon, as well as other boroughs. • Instructed officers to approach Legal Services to clarify the conflict between the Children's Act 2004 and the Education Act 1996 (see page 12 (2.2) in the agenda). The Chairman thanked the witnesses for attending the meeting and informed them that their views would be taken into account when writing the Review report on Elective Home Education in Hillingdon.	Pauline Nixon Anna Crispin
39.	**CONSULTATION ON ELECTIVE HOME EDUCATION DRAFT POLICY** *(Agenda Item 8)* In introducing the report, officers advised that the Education Maintenance allowance (page 34 (5.10) mentioned in the report had now ended and had been replaced by the 16 – 19 Bursary Fund. Given the issues raised during the witness session discussions, the Committee indicated that the Policy should be amended and reported back to a future meeting. Officers advised that the amended Policy would be reported to the Committee once it had been reviewed by the Sub-Group of the Local Safeguarding Children's Board at its meeting on 4 November 2011. It would then be reported to Cabinet for Approval. Members were invited to submit written comments to Deborah Bell - Service Manager, Special Needs Behaviour by the 3 November 2011.	**Action by**
40.	**FORWARD PLAN 2010/2011** *(Agenda Item 9)* The Committee received a report setting out the Education items on the Forward Plan listing forthcoming reports and decision to be made by Cabinet and individual Cabinet Members from October 2011 onwards.	**Action by**

	Resolved – That the information in the report be noted.	
41.	**WORK PROGRAMME 2010/2011** *(Agenda Item 10)* The Committee indicated that a further witness session inviting young people who had been home educated and had progressed to college or university (or currently studying) would be valuable to the Review. This witness session would enable the Committee to gain an insight into the personal experiences of how the young people had benefited from having been home educated. Written submission would be welcomed also, as it was acknowledged that some young people may not wish to attend a meeting to relay their experience. **Resolved – That the work programme be noted and that it be updated as necessary.**	**Action by** Deborah Bell
	The meeting, which commenced at 7.00 pm, closed at 9.50 pm.	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nadia Williams on 01895 250693. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

FIRST MAJOR REVIEW – ELECTIVE HOME EDUCATION - WITNESS SESSION

Contact Officer: Gill Brice
Telephone: 01895 250693

REASON FOR ITEM

To enable the Committee to gather evidence as part of their First Major Review in relation to Elective Home Education (EHE).

OPTIONS AVAILABLE TO THE COMMITTEE

1. Question the witnesses
2. Highlight issues for further investigation
3. To make a note of possible recommendations for the review

INFORMATION

1. At this Committee's meeting on 5 July 2011 approval was given to the committee undertaking a review on Elective Home Education. The Aim of the review was to provide a balance of both safeguarding issues and the rights of parents within the EHE Policy ensuring lawfulness and mindful of the views of Residents.

2. At the Committee's second witness session on 19 October 2011, Members heard from 5 witnesses, four parents of EHE Children and a representative of the Home Education Advisory Services. Details of the evidence provided at the witness session is detailed in the minutes which are attached to this agenda.

HOME EDUCATION ADVISORY SERVICE (HEAS)

3. For Members information and taken from HEAS' website, "HEAS is a national home education charity based in the United Kingdom. It is dedicated to the provision of advice and practical support for families who wish to educate their children at home in preference to sending them to school. Interest in home education is increasing and HEAS recognises that reliable information should be available for everyone. HEAS was established in 1995 by a group of experienced home educators in order to provide good quality information on both the legal and practical aspects of home education. Since then HEAS has given information to many families and also to education authorities, other professionals, academic researchers, politicians, voluntary agencies, the media and other bodies.

4. HEAS offers information for home educators including advice about educational materials, resources, GCSE examinations, special educational needs, information technology, legal matters and curriculum design. HEAS produces a range of leaflets and the Home Education Handbook. In addition HEAS subscribers receive the quarterly HEAS Bulletin, access to the Advice Line, contacts with other subscribers and the HEAS registration card (for home educating families) which gives free or reduced rates of admission to certain museums and sites of interest.

5. HEAS believes that every parent should receive full information about their children's education - including information about the facts of home education. Many parents say "I wish I'd known about this years ago", and HEAS is working to increase public awareness of home education. Some parents choose the home option at the outset, while others undertake it as a last resort when there are insuperable problems at school. There are many different reasons but HEAS upholds the right of parents to make their own arrangements for their children's education at home. HEAS believes that home education has much to offer and the experience of many families shows that it can be enjoyable and rewarding for both parents and children."

6. Subsequent to the meeting, the representative from HEAS has submitted written information which I attach for Members information as **Appendix A.** Members should give consideration to the issues raised in the written information which are integral to the Committee's review.

7. Officers will be attendance to provide a response to the issues raised in the correspondence.

WITNESSES

7. For this third witness session it is hoped that the Policy Overview Committee will be hearing from a randomly selected number of formerly home educated young people that have now moved through to higher education. Four young people have been written to asking if they would attend the meeting to help the Committee with its review. As of the publication of the agenda there has been no response to these invitations. The young people were given the alternative option of providing a written submission, should they not be able to attend the meeting.

PAPERS WITH THE REPORT

Letter from HEAS – Appendix A

Scoping report attached as Appendix B

SUGGESTED COMMITTEE ACTIVITY

Members question the witnesses and identify important issues for their review.

Members identify areas where further information and evidence is required to help greater understanding of the issues.

Members to give consideration to initial recommendations for the review.

APPENDIX A

Home Education Advisory Service

Cllr C Dann
Chairman
Education and Children's Services Policy Overview Committee
Conservative Group Office
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9 November 2011

Dear Cllr Dann

Review: Elective Home Education policy

Thank you very much for giving me the opportunity to attend and speak to Hillingdon's Education and Children's Services Policy Overview Committee on 19th October. I am writing to send you some further information on the matters which I raised during the Witness Session, as I undertook to do at the time.

At the outset I would like to assure you on behalf of Home Education Advisory Service (HEAS) and the group of concerned home educators from the Borough that we do not wish to be adversarial over the matter of Hillingdon's Elective Home Education policy and procedures. As a national registered charity working in the field of home education, HEAS has endeavoured to improve relationships between home educators and LAs during the 16 years that it has been in existence. We have often assisted LAs during reviews of their policies and procedures and we know how crucial these matters are in fostering good relationships between both parties. We understand the Council's concerns and on behalf of the local parents present and also on behalf of the trustees of Home Education Advisory Service I would like to give you a sincere assurance of our good will in the matter of the safety and welfare of children generally. We have no desire to be legalistic but we do recognise that home education policies give assistance and protection to all concerned if they are solidly based in law.

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Hillingdon's draft EHE policy for consultation

HEAS is very concerned about the fact that the draft Elective Home Education Policy for consultation which has been presented to the Education and Children's Services Policy Overview Committee (as included in Public Document Pack A) is deficient in many respects. It appears to be a hasty and superficial revision of the 2009 policy which, although it is said to have been through 'due process', contains some significant errors.

The DCSF issued a document entitled *Elective Home Education Guidelines for Local Authorities* (EHEGLA) in 2007 in the name of the Minister of State for Schools and Learners and bearing his signature. This is the standard document which is used by local authorities in order to ensure that their elective home education policies conform to the law. I have to inform you that Hillingdon's 2009 policy, together with the current draft policy for consultation, appear to have been based on an early uncorrected draft of the DCSF document which differs in some important respects from the final version of EHEGLA that bears the signature of the Secretary of State. You will be able to see for yourself that this early draft, with consultation questions appended, still appears on the internet when a search in undertaken. Other local authorities have also made the mistake of assuming that this is the current version. The current document *Elective Home Education Guidelines for Local Authorities* may be found on the DfE website at the following link:

http://media.education.gov.uk/assets/files/pdf/e/guidelines for las on elective home education.pdf

There is an urgent need to examine Hillingdon's consultation draft policy thoroughly before matters proceed any further. I have annotated the draft but to go into the details here would make this letter unacceptably long. I would be glad to provide further information on this matter and I am more than willing to meet with your officials and assist in the preparation of a document that is based on the correct information. EHEGLA states (paragraph 1.3) that the guidelines were issued 'to support local authorities in carrying out their **statutory** responsibilities and to encourage good practice by clearly setting out the legislative position, and the roles and responsibilities of local authorities and parents in relation to children who are educated at home'. Unfortunately the draft policy cannot be said to fulfil these aims as it stands.

HEAS has been advised that if a local authority were obliged to take legal action or if action were taken against them, their policy would be subject to scrutiny; if the policy could be shown to be in error (as would be the case with the draft policy under consideration) the local authority would be open to censure.

Matters arising from the minutes of the first Witness Session

In addition to studying the draft policy we have also considered the minutes of the first Witness Session which the Committee held in September 2011. The minutes record a number of significant errors of fact that were included in the information which was presented to the Committee. These are as follows:

Bullet point 1: the claim is made that there is 'a conflict between the Children Act and the Education Act 1996'. The alleged 'conflict' between parents' educational rights and local authorities' safeguarding duties does not exist. Parents and carers bear the responsibility of ensuring that their children are safe, not local authorities. It was not the intention of Parliament to remove this duty from parents and place it upon local authority officials. The *Every Child Matters* initiative does not give local authorities the duty to carry out universal surveillance of every child in the country. Their duty is to be alert during the course of their duties for signs that a child might be at risk and to act upon them promptly. Section 175(1) of the Education Act 2002 gives local education authorities a general duty to exercise their functions with a view to safeguarding and promoting the welfare of children. Section 11 of the Children Act 2004 extends this duty to all other functions of the local authority, but it adds no new responsibilities.

In particular there is nothing in Section 11 or in any other part of the Children Act 2004 which gives local authorities the power to enter homes in order to see children unless there is reasonable cause to believe that the child is suffering, or likely to suffer significant harm. Home education itself cannot be cited as a ground for concern about a child because this is a lawful activity for parents by virtue of Section 7 of the Education Act 1996.

The DfES document *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004* (2007) states that 'under the Children Act 2004, LAs have a responsibility for making arrangements to ensure their normal functions are discharged having regard to safeguarding and promoting the welfare of children in their area. This includes all types of LA services involving adults, children and families ...' (section 3.3) . This duty applies to Hillingdon's Elective Home Education Service in terms of requiring any staff member to be alert for signs of abuse or neglect when they are acting in the normal course of their duties. It does not empower them to carry out investigations when there are no grounds for suspicion of a problem. Indeed, it does not empower them to carry out investigations at all: it is their duty to report to the relevant authorities any concerns that may arise during the performance of their duties.

Section 2.4 of the statutory guidance mentioned above also confirms that the duty does not give agencies any new functions. It requires them 'to carry out their *existing functions* in a way that takes into account the need to safeguard and promote the welfare of children' (emphasis ours). HEAS raised the matter of the boundaries of the LAs' safeguarding duty with Elaine Haste of the DfES Home Education team at a meeting in July 2007. Ms Haste confirmed that local authorities should not go looking for safeguarding issues amongst home educating families. Ms Haste stated that the duties placed upon local authority staff are exactly the same as those given to GPs, the health authorities and other professionals; if any issues are suspected during normal contact with a child, local authority representatives should pass on their concerns to 'the relevant authorities'.

Bullet point 2: this states that 'Parents had rights to home educate and children had rights in relation to safeguarding'. This statement does not take account of the fact that in all but the most extreme cases, the duty to keep a child safe belongs to the parent. The duty to safeguard children does not give GPs the power to insist on

carrying out health checks on every child. Dentists are not empowered to demand that children should attend for checkups. Police officers cannot go from house to house to investigate whether or not children are involved in crime. Teachers' duty to safeguard children has been turned on its head by the assumption that home educated children are missing out on the safeguarding role of schools. The duty to safeguard and promote the welfare of children obliges teachers to notice and report any concerns but it does not override the duty of parents, who are the primary guardians of the rights of their own children.

Bullet point 7: this states that the aim is for all children to be seen annually by the LA or by a 'recognised professional body advising that a child was safe'. This aim would appear to be a 'box-ticking' exercise: how could children's safety possibly be assured by a visual inspection once a year? This objective creates the illusion of having taken action but it is dangerous because it could easily lead to complacency. All the evidence points to the fact that children die because both professional agencies and individuals in the community had ongoing concerns but failed to act in time to save them. This is not an attempt to apportion blame and it is acknowledged that many factors make it very difficult to decide on the right moment for intervention in such cases. It is also evident that any attempt at some kind of universal surveillance is extremely wasteful of scarce resources and expertise; further, many false positives would result. Investigations in these cases would cause severe trauma and distress to innocent families while diverting attention away from known cases where children are vulnerable and in need of help.

Bullet points 12 and 13: the claim is made here that 'The Elective Home Education (EHE) policy had been through due process and had taken into consideration and struck a balance between both the Education Act and the Children Act'. The policy in question may have been agreed by the multi-agency Policy sub-group and signed off by the Local Safeguarding Children's Board but it is incorrect and not fit for purpose. It is in urgent need of reconsideration to bring it in line with current law and good practice. The policy as it stands is certainly not legally compliant as stated in bullet point 13 and it is an incorrect precis of the law to state that 'there was an overriding duty around safeguarding'. There is no statute which gives total and absolute power to any agency in all situations without any checks or balances, as the word 'overriding' suggests.

Bullet point 14: this states that 'There was a right for officers to see a child that had not been seen by another professional for a year or more'. There is absolutely nothing in either primary or secondary legislation which justifies this extraordinary statement. It is totally without foundation. Only in exceptional cases should there be compulsory intervention in family life - for example, where this is necessary to safeguard a child from significant harm (Working Together to Safeguard Children (2010), paragraph 1.6).

A senior social worker from another LA area has advised home educators: 'I know of no provision that gives local authority officers the right to knock on doors unannounced and demand to see children ... Section 2.12 of the DfES document *Elective Home Education: Guidelines for Local Authorities* (2007) states that local authorities' duty under section 175(1) of the Education Act 2002 does not extend their functions. Any local authority which claims that they have the power to enter homes

and see children just in case abuse might be going on, should be asked to supply the exact wording of the text of the statute, regulation or guidance, with full reference, that they consider justifies their procedure. Such a power does not exist.'

Bullet point 15: the statement is made that 'Over the last 20 years there had been a number of case reviews, where it had been highlighted that no proper safeguarding measures had been put in place for a child not seen by professionals'. We recommend that the Committee seeks further specific information about this general and rather vague statement. HEAS has not found any evidence to support this assertion.

Research studies available on the DfE's website show that in many cases the families of abused children were well known to several agencies. Poor communication between professionals has been a factor in many cases; delay in responding to concerns has led to tragedy in many instances and professionals have been deceived by manipulative parents who present a caring and capable appearance to them. Workers have passed on concerns and considered that their responsibility was thereby ended, and the concerns were not acted upon; often, officers have been intimidated by aggressive and threatening parents; in some cases, ambiguities may have caused professionals to hesitate in the absence of unequivocal warning signs. In the overwhelming majority of serious cases, it is clear that the families and their problems have been known to a number of agencies for some time.

It is clear that in a small minority of cases no warning signs have been evident prior to a tragedy occurring. It is an unavoidable truth that if parents or carers are sufficiently evil or deranged to be capable of hiding children away altogether, no policy or procedure will be able to give them the protection that they deserve. In these cases the most effective means of safeguarding children lies with the local community, including the home educators who are being alienated by a wasteful and unlawful policy of unannounced visits.

Bullet points 16 and 17: after commenting on the tension caused by unannounced visits, the statement is made that 'There would always be a minority of home educated children that needed to be safeguarded and there was a duty on LA officers to protect each child'. The next point states that there needed to be 'a balance between these two absolute rights for a child to be educated at home and to be safeguarded in the EHE policy'. These comments reveal the confusion that exists about the nature of the LA's duty to safeguard and promote the welfare of children. It is the primary duty of parents both to protect their children and to ensure that a proper education is provided for them.

The local authority's safeguarding duty is general, not particular, and it is stated correctly in the Policy Overview and Scrutiny Committee's report: 'Members and Residents will be assured that Hillingdon children are safeguarded as far as is reasonably possible'. The local authority has a responsibility for ensuring that they make appropriate arrangements to safeguard and promote the welfare of all children. Such arrangements might include subsidised sports and leisure services, access to health services and ancillary services including speech therapy; they must include child protection training for all professionals who might come across home educated children during the performance of their duties. All professionals must be briefed on the proper procedures for making referrals to the relevant agencies if any child

protection concerns should arise in the course of engagement with home educated children. The duty to ensure that 'appropriate arrangements to safeguard and promote the welfare of children are in place for all children residing within their area ' (*Working Together to Safeguard Children* (2010), paragraph 2.21) is not the same as 'a duty on LA officers to protect each child ' and the local authority's responsibility cannot be interpreted as such.

Bullet point 18: the assertion is made here that the Badman review 'highlighted a number of loopholes in relation to safeguarding'. This is the *Review of Elective Home Education in England* by Graham Badman (2009) which was commissioned by the then Secretary of State for Children, Schools and Families. We were disturbed to see that the report of the Badman review is also listed under 'Intelligence' in Hillingdon's Policy Overview Committee Review Scoping Report. We must point out that this discredited document is not a reliable source of evidence.

The Badman Review of Elective Home Education in England

The Badman review was ill-considered and hastily executed: it was badly flawed and roundly condemned not only by home educators but also by many MPs, many academics and by a number of professionals in the fields of education and safeguarding. The seriousness of the complaints received led to the conduct of the review being investigated by a House of Commons Select Committee of Inquiry which published its report on 9 December 2009. Shadow Education Secretary Michael Gove noted in debate in the House of Commons that 'I have become particularly worried about the way in which various issues have become conflated; I am especially worried about the conflation of safeguarding and child protection with quality of education.' (Hansard 11 Jan 2010, Column 456).

The Select Committee Inquiry found that Badman's figures were improperly calculated, including elementary mathematical errors. The review itself was discredited and none of its recommendations was implemented.

In his submission to the Select Committee Professor James Conroy, himself a member of the Badman review's reference group, states: 'In my 30 odd years of professional life in education I have rarely encountered a process, the entirety of which was so slap dash, panic driven, and nakedly and naively populist. From the moment Baroness Morgan publicly announced the terms of reference as based on a number of assumptions, not least of which was that home education might be a haven or harbour for various kinds of child abuse, the stage was set. Of course anything could be a shelter for anything else - to say so is to say nothing. No account was given of any substantial empirical evidence of the prevalence of abuse in home education environments or whether there was a greater incidence of such abuse amongst home educators than was more generally true of the population as a whole, or perhaps, more tellingly, in state sponsored care facilities. In the report itself Badman compounds the felony with a raft of unsubstantiated claims based on hearsay and vague generalisation.'

Professor Eileen Munro, in her response to the Select Committee Inquiry, is also critical of the review. After exposing the author's 'muddled thinking' and observing

the ‘risk of harm’ from losing the few genuine concerns amidst a mass of irrelevant data obtained from routine surveillance, her submission concludes: ‘Overall, I think this report confuses two overlapping agendas - to promote the welfare of children and protect them from maltreatment. It also overlooks or underestimates two current sources of safety for children: the current child protection system and the importance of community support and monitoring of home education.’

Much more could be said about the shortcomings of the review and we are shocked to find that it has been recommended to the Committee as a source of evidence on home education. We would urge the Committee to read the Select Committee of Inquiry’s Report as well in order to put the Badman report and its ‘findings’ into proper perspective.

‘Legislative Changes’? A request for clarification

We would like to ask for clarification of a point that is made in the ‘Risk Assessment’ section of the Policy Overview Committee’s scoping report (on the final page). The comment is made that ‘There may be Legislative Changes required arising from the review’. What does this statement mean? Does the statement refer to the Badman review when it suggests that changes to the law may be required? If so, could we please point out that the legislative changes which were proposed in the Children’s, Schools and Families Bill were removed during the final stages of the passage of the Bill and the Badman review is no longer relevant. Any future consideration of the law of home education would of necessity be informed by a fresh inquiry.

Home education policy: an example of good practice

We note that the Policy Overview Committee includes in its terms of reference a commitment to looking at sources of good practice and to recommend a revised policy to Cabinet. May we suggest that you consider the policy which is in use in Gloucestershire? The policy may be seen on Gloucestershire County Council’s website at http://www.gloucestershire.gov.uk/index.cfm?articleid=813 together with the associated documents. Key to the success of this policy is the work of EHEGLOS, the department which provides the county’s elective home education service, and the work of its advisers over many years which has resulted in a very good and trusting relationship with the local families.

Unannounced visits: an ineffective and potentially dangerous procedure

It is a matter of concern to us that the Council’s unannounced visits procedure not only angers and insults decent and reasonable parents, but it could also contribute to a negative outcome for a child who might actually be at risk. We note that the consultation draft of the EHE policy, as included in the Public Document Pack A, includes this statement at section 3.10: ‘Should a family choose to have no contact with the Local Authority whatsoever, or the child have no alternative Community links, the Local Authority may attempt to visit the family at home, by appointment or not, to carry out Hillingdon’s safeguarding duty. ... Ultimately, if there is no indication that the child has been seen by anyone outside the home for a period of time not less than three months, a Common Assessment Framework may be completed and guidance sought from Social Care Officers.’

If a parent has withdrawn a child from school and has failed altogether to respond to the EHE Department's initial informal enquiry about the educational arrangements, the LA might reasonably conclude that suitable education is not being provided. If it has been impossible to obtain any information from the family by this point it is hardly likely that they would agree to co-operate with the completion of a common assessment, and the assessment may only be carried out with the family's consent. Further, if no information is forthcoming from a family who is known to other agencies and there are existing concerns about a child, it would be reasonable for local authority staff to serve the parent with notice of their intention to apply to the court for a School Attendance Order under Section 437(1) of the Education Act 1996. In this case an attempt to complete a common assessment after a delay of three months would not be an appropriate procedure; if a child were at risk it would be dangerous to delay before following up any concerns.

We must add that failure to see a child or to hear from a family would not of itself be a reason for concern about a child's welfare. HEAS has always had some subscribers who are away for months at a time for various reasons. These include an Associated Board Music examiner who does tours of duty overseas and takes his family, a number of showmen who provide excellent education for their children while they are travelling with their fairgrounds, missionaries who travel with their children and others of various nationalities who visit relatives for extended periods both at home and abroad. Some families move out of the area and they are under no obligation to inform anyone if they decide to do so. It would be an improper use both of public funds and a waste of scarce resources to pursue such families when they have broken no law and when there is no indication of any cause for concern.

Safeguarding children: the community's important role

The law makes it clear that protecting children from maltreatment is everyone's responsibility; it is not a duty which is given solely to the local authority and to other public agencies. EHEGLA states (paragraph 4.7):

'The welfare and protection of all children, both those who attend school and those who are educated at home, are of paramount concern and the responsibility of the whole community. Working Together to Safeguard Children (2006) states that all agencies and individuals should aim proactively to safeguard and promote the welfare of children. As with school educated children, child protection issues may arise in relation to home educated children. If any child protection concerns come to light in the course of engagement with children and families, or otherwise, these concerns should immediately be referred to the appropriate authorities using established protocols.'

It is sensible for local authorities to build good relationships with local home educating families because they are very well placed to complement the local authority's safeguarding role. These families will be in contact with many others who are not known to the local authority. In some parts of the country the local authority's EHE department has asked the known local home educators for a volunteer who is willing to act as a contact for new families. When the EHE staff receive notification of a child who is new to home education they give details of the voluntary contact

person to the child's parents. This service is of benefit to the new family as it enables them to join in all or some of the local activities as they wish. It should be noted, however, that if the family decides that the local activities are not suitable for them this should not be regarded as a cause for concern.

Home educators are well placed to help other families who are not known to the LA. Over the years I have seen many examples of parents in local groups helping others who may be facing difficulties. I have witnessed many instances of parents giving practical help and support in situations where without that help children might have been considered to be vulnerable or in need. In addition, in the course of the 23 years during which I have been personally involved with home education at a national level there have been a handful of cases where home educating families in a local area have had concerns about a child. Safeguarding children is everyone's priority and parents in local home education groups do take this responsibility seriously. It is crucial that parents should feel able to seek advice if they have concerns, but if relationships between home educators and the local authority have been soured by an insistence upon unreasonable and unjustified procedures it would be very difficult for them to do so.

I have so often been impressed and humbled by the altruism, dedication and public-spiritedness of so many of the home educating parents with whom I have been privileged to work over the past 24 years. I would like to emphasise that the Hillingdon home educators do not wish to be obstructive, but they wish to complain about procedures that are *ultra vires*, offensive, misdirected and counter-productive. They have all stated that confusion between educational and safeguarding matters can only result in procedures that fail to achieve satisfactory results in either area.

I do hope that it will be possible to address the matter of the inadequacy of the draft policy before the revised draft reaches the Cabinet for ratification. Taking into account the errors and misapprehensions that are recorded in the minutes of the first Witness Session of the Education and Children's Services Policy Overview Committee, together with the draft EHE policy as it stands at present, we fear that Hillingdon is in danger of adopting a new policy which is not in accordance with the law.

On behalf of my fellow trustees of HEAS I would like to emphasise that we would be happy to assist Hillingdon Council's Elective Home Education Department in any way that we can. We are committed to working co-operatively with all local authorities in order to promote our shared goal of improving outcomes for children and families.

With all good wishes,

Yours sincerely

(Mrs) Jane Lowe
for the trustees of Home Education Advisory Service

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APPENDIX B

HILLINGDON
LONDON

Education & Children's Services Policy Overview & Scrutiny Committee
Review Scoping Report 2011/12

OBJECTIVE

ELECTIVE HOME EDUCATION (EHE) IN HILLINGDON

Aim of Review

This review aims to review the Council's Elective Home Education Policy and the balance of both safeguarding issues and the rights of parents.

Terms of Reference

- To look at the reasons why parents opt for EHE.
- To analyse at what stage parents decide to opt for EHE.
- To consider the needs of people within the EHE Community for inclusion in the policy.
- To look at all sources of good practice and to recommend a revised policy to Cabinet.
- To look at the psychological development of children that are home educated
- To look at partnership arrangements associated with EHE.
- To look at how attainment progress is measured.
- To look at the transition to formal education if and when they choose to take that step.

Reasons for the review

At the last meeting of the Committee, Members were informed of some issues that were ripe for review regarding the children whose parents had decided would be educated at home. The Council has an existing Elective Home Education Policy but it needs to be updated to reflect a more balanced approach to both safeguarding issues and the rights of parents. This would be a potential review involving both internal and external witnesses, including parents and young children. This is a service area that has not been reviewed at Member-level for a long time. Such a review would also result in a new policy on this matter being presented to Cabinet by the Committee.

The Hillingdon EHE Policy in partnership with the Local Safeguarding Children's Board (LSCB) was ratified in 2009. The Policy has been delivered ever since.

In February 2011, a Member was contacted and met with a group of EHE parents, some being Hillingdon Residents. This group expressed concerns that unannounced 'safeguarding' ad-hoc visits to EHE homes by Hillingdon officers were unlawful and unwelcome.

Subsequently, the ad hoc visiting element of the Hillingdon EHE Policy has been on hold pending a full review of the policy.

Members and Residents will be assured that Hillingdon children are safeguarded as far as is reasonably possible. Delivery of EHE is of a quality and quantity to prepare Hillingdon children to be contributing members of society when adults

Supporting the Cabinet & Council's policies and objectives

Hillingdon Children's & Family's Trust Plan priorities:

- P1 Keeping children and young people safe
- P2 Ensure all children have a good start to life

INFORMATION AND ANALYSIS

Key Issues

There is a conflict in the Education law in regard to EHE and the Children's law in relation to safeguard.

The responsibility for a child's education rests with their parents. In England, education is compulsory (for children aged 5 to 16), but schooling is not.

2.2 Article 2 of Protocol 1 of the European Convention on Human Rights states that:

> *No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching is in conformity with their own religious and philosophical convictions.*

This right is enshrined in English law. Section 7 of the Education Act 1996 provides that:

> *The parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable -*
>
> *(a) to his age, ability and aptitude, and*
>
> *(b) to any special educational needs he may have,*

either by regular attendance at school or otherwise.

And Section 9 of the Education Act 1996 provides that:

> *In exercising or performing all their respective powers and duties under the Education Acts the Secretary of State local education authorities and the funding authorities shall have regard to the general principle that pupils are to be educated in accordance with the wishes of their parents, so far as that is compatible with the provision of efficient instruction and training and the avoidance of unreasonable public expenditure.*

In conjunction with this, The Children Act 2004 places duties on the Local Authority to:

- safeguard and promote the wellbeing of children in partnership with children and young people, parents and carers, and the wider community.

Remit - who / what is this review covering?

Access and Inclusion Service (Planning, Environment, Education and Community Services)

The Home Education Advisory Service - http://www.heas.org.uk/

The Hillingdon Safeguarding Children's Board

Connected work (recently completed, planned or ongoing)

Revised EHE draft Policy for Hillingdon, which has been agreed by Access & Inclusion (PEECs),

LBH Legal Services and the Hillingdon LSCB and a background report for information.

Key information required

The proposed EHE Policy for Hillingdon, Sections 7 & 9 of the Education Act 1996 and the Children Act 2004.

EVIDENCE & ENQUIRY

Scrutiny of documents available on EHE.
Consideration of information provided by witness sessions from officers, stakeholder agencies and other interested parties.

Witnesses

- Education Officers (PEECS)
- Representative from the Home Education Advisory Service
- Paul Hewitt – Safeguarding, Social Care, Health & Housing
- Parents providing EHE for various reasons.

- An older child that has been home educated

Information & Intelligence

Intelligence

http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/Local-authorities-and-home-education
Local Authorities and Home Education
http://www.heas.org.uk/
Badman Review
European Convention on Human Rights - Article 2 of Protocol 1
Sections 7 & 9 of the Education Act 1996.
The Children Act 2004

Information

This is a contentious area and many EHE parents across the country are passionate about the field. The previous Government commissioned the Badman Review with a view to altering current legislation. Members may wish to read this review and be familiar with the response from the EHE community.

The Home Education Advisory Committee has represented a minority of Hillingdon EHE parents who were dissatisfied with the previous Hillingdon policy of ad hoc visits when a child had not been seen for a year. A Member met a group of EHE parents expressing this view in February 2011.

Consultation and Communications

Hillingdon has a standard information letter and leaflet available on line or through the Contact Centre/EWS Duty Line to support and advise EHE parents.

Consultation with Hillingdon EHE parents has been planned for the proposed revised policy. With the POC leading on this review, it can undertake this consultation as part of the review and through its witnesses.

Lines of enquiry

How does LBH propose to support EHE parents to ensure all residents children are safe when they are not seen in the wider community?

PROPOSALS

Recommendations will be put forward following the witness sessions.

LOGISTICS

Proposed timeframe & milestones

Meeting Date *	Action	Purpose / Outcome
5 July 2011	Agree Scoping Report and Presentation by officer	Information and analysis
September 2011	Witness Session 1	Evidence & enquiry
October 2011	Witness session 2	Evidence & enquiry
November 2011	Witness session 3	Evidence & enquiry
January 2012	Draft Final Report	Proposals – agree recommendations and final draft report

** Specific meetings can be shortened or extended to suit the review topic and needs of the Committee and additional meetings arranged when required.*

Risk assessment

There may be Legislative Changes required arising from the review.
Policy may not please all stakeholders
There are tensions between the LA statutory safeguarding responsibilities and current EHE Legislation.

Equality Implications

The Council has a public duty to eliminate discrimination, advance equality of opportunity and foster good relations across protected characteristics according to the Equality Act 2010. Our aim is to improve and enrich the quality of life of those living and working within this diverse borough. Where it is relevant, an impact assessment will be carried out as part of this review to ensure we consider all of our residents' needs.

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DRAFT ANNUAL REPORT OF THE HILLINGDON SAFEGUARDING CHILDREN BOARD

Contact officer Paul Hewitt
Telephone ext 0410

REASON FOR ITEM

The Committee is invited to note and comment on the Annual Report as part of its scrutiny function of Council services, and as part of the overall Council responsibilities to safeguard children and young people.

OPTIONS AVAILABLE TO THE COMMITTEE

To comment and query the report prior to final sign off of by the Local Safeguarding Children Board (LSCB) on 25th Nov 2011 and presentation to Cabinet in January 2012.

INFORMATION

1 Background and context

1.1 The LSCB is a statutory multi-agency body established with the overall aim of monitoring, overseeing, supporting and challenging the work of all agencies with regard to their responsibilities to safeguard and protect children. LSCBs are required to produce an annual report which comments on the effectiveness of local arrangements to safeguard children. (The Apprenticeships, Skills, Children and Learning Act 2009) This is the first annual report under the new requirements and we are required to publish this report by 1 April 2012.

1.2 The following areas are required elements of the Report (Working Together 2010)

- An assessment of local arrangements to safeguard and promote the welfare of children, to include achievements and challenges
- An assessment of the effectiveness of policies and procedures to recruit and train frontline staff
- An assessment of progress in implementing lessons from Serious Case reviews and child death reviews
- An assessment of progress in key priority areas (e.g. child trafficking)
- A challenge to the work of the Children's Trust Board in driving improvements in safeguarding

2 Summary of findings

2.1 Overall, evidence available to the LSCB indicates that children are well safeguarded with some areas for development that are in hand. There is evidence of strong multi agency working and commitment and a large number of tasks and actions have been progressed under the auspices of the LSCB

2.2 The increase in child protection activity noted in 2010 has stabilised at a high level. This increase in child protection activity has had an impact on all agencies, particularly specialist services. This workload has to be absorbed in order to ensure that children are kept safe, but the workload, along with staffing capacity to deal with it, is putting a strain on all services.

2.3 This will be exacerbated by reductions in available resources and in changes in partner agencies, particularly Health.

2.4 The LSCB is continually developing ways of scrutinising services to ensure that these changes do not place children at unnecessary risk, and the annual report includes in its recommendations those targeted areas of activity that are likely to achieve most benefit

2.5 The LSCB also strongly recommends that resources are secured and protected for specialist front line services who work with children at risk of harm.

2.6 The Council is currently leading on the development of early intervention services. The LSCB recommends that these are multi agency and that they have clear pathways and provision for co-ordinated plans and services, targeted at those most in need .

2.7 The LSCB would also welcome the opportunity to contribute to service commissioning, particularly health services for under fives and mental heath services.

BACKGROUND PAPERS

Working Together to Safeguard Children 2010. Chapter 3

Lynda Crellin
Independent Chairman
Hillingdon LSCB
Nov 2011

Hillingdon Local Safeguarding Children Board
Draft Annual report
2010-11

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

November 11th 2011

INDEX

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

WHAT WE HAVE DONE

What we planned to do – our key priorities

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

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

Priority 1 Improving infrastructure and functioning of LSCB

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

Priority 2 Ensuring effective and improving operational practice

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

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

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

Domestic Violence:

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

Adult mental health:

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

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

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

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

E-safety:

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

Trafficking:

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

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

Disabled children and young people:

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

Priority 6 Ensuring a safe workforce

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

Priority 7 Learning from SCRs and CDOP

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

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

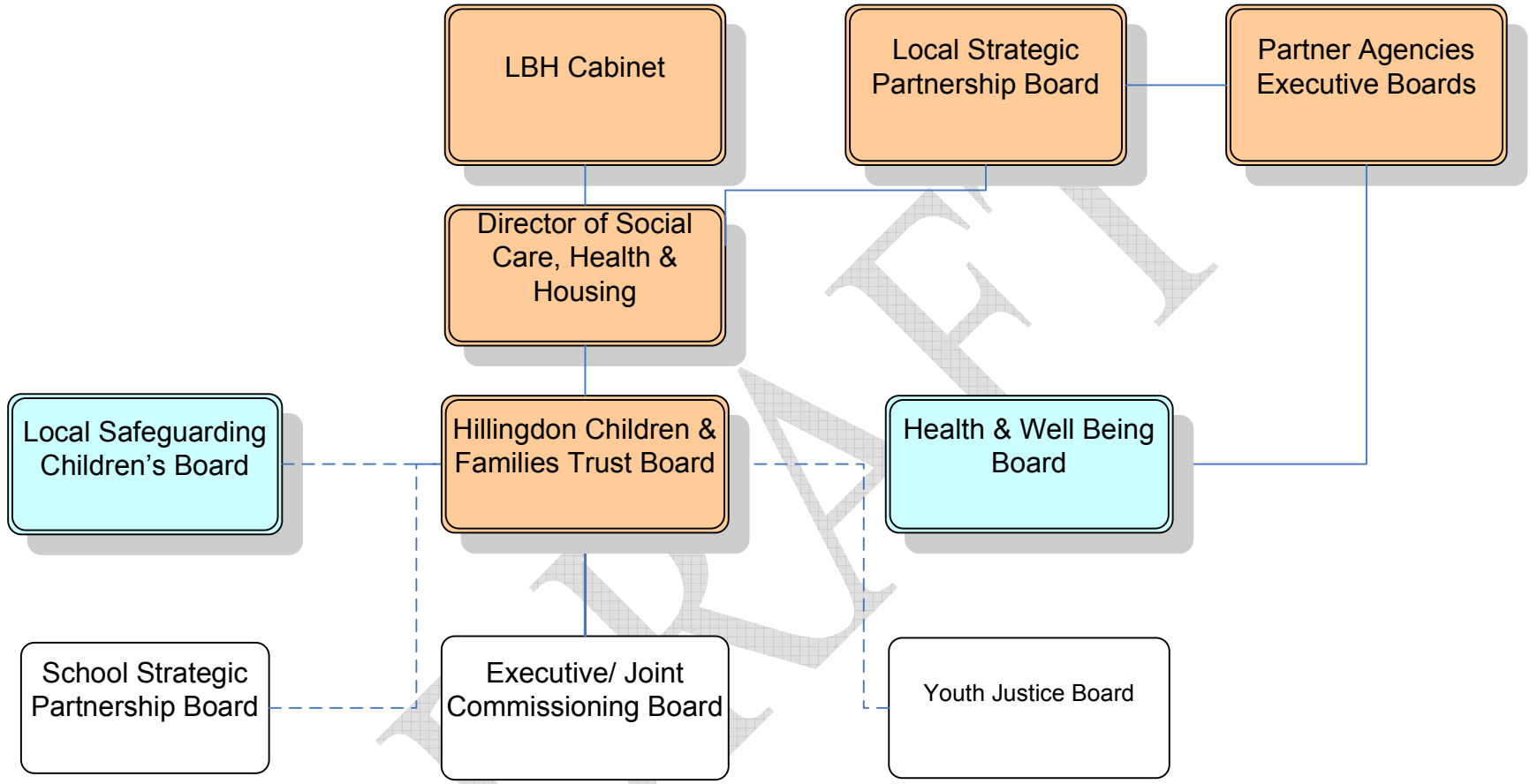
Operation

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

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

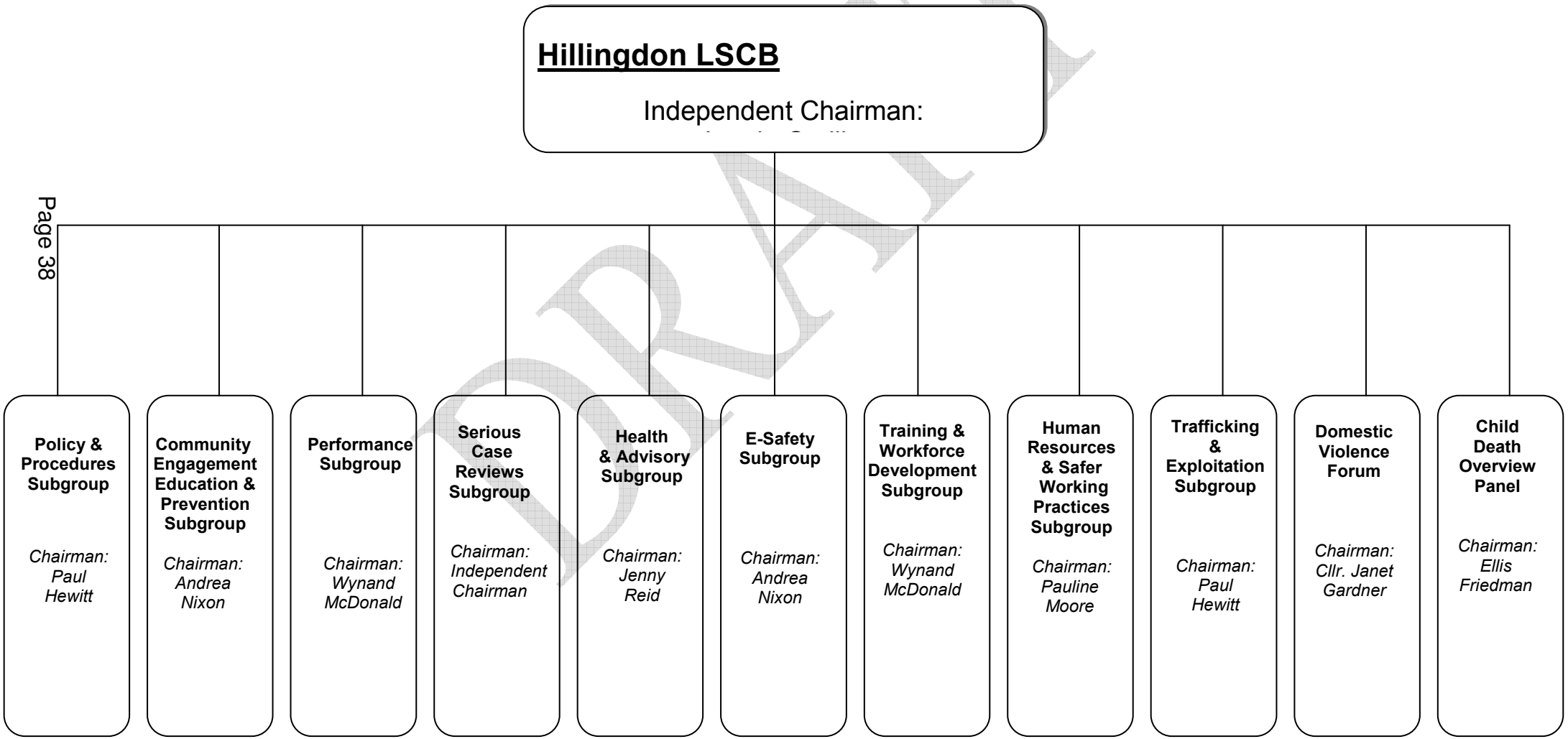
Although there is no longer a statutory requirement to have a Children's Trust, the Hillingdon Children and Families Trust Board (HCFTB) continues to meet in order to oversee the Children and Families Plan. The LSCB chairman sits on the HCFTB and though regular updates ensures that the HCFTB is kept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

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



LSCB governance

THE STRUCTURE OF HILLINGDON'S LOCAL SAFEGUARDING CHILDREN BOARD



Membership

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

Independent chairman

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

Relationship to agency boards

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

Hillingdon Council

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

Social Care

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

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

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

Education and Early years

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

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

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

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

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

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

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

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

Voluntary Sector

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

Health Agencies

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

Hillingdon Community Health

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

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

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

The Hillingdon Hospitals NHS Foundation Trust

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

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

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

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

Central and North West London Health (CNWL)

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

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

Metropolitan Police

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

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

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

Child Abuse investigation team (CAIT)

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

Financial arrangements

The LSCB is funded in partnership by the following agencies:

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

LEARNING FROM CASE REVIEWS

Serious Case Reviews (SCRs)

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

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

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

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

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

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

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

Other case reviews

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

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

Child Death Overview Panel (CDOP)

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

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

WORKFORCE

Evaluation of single and multi agency training

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

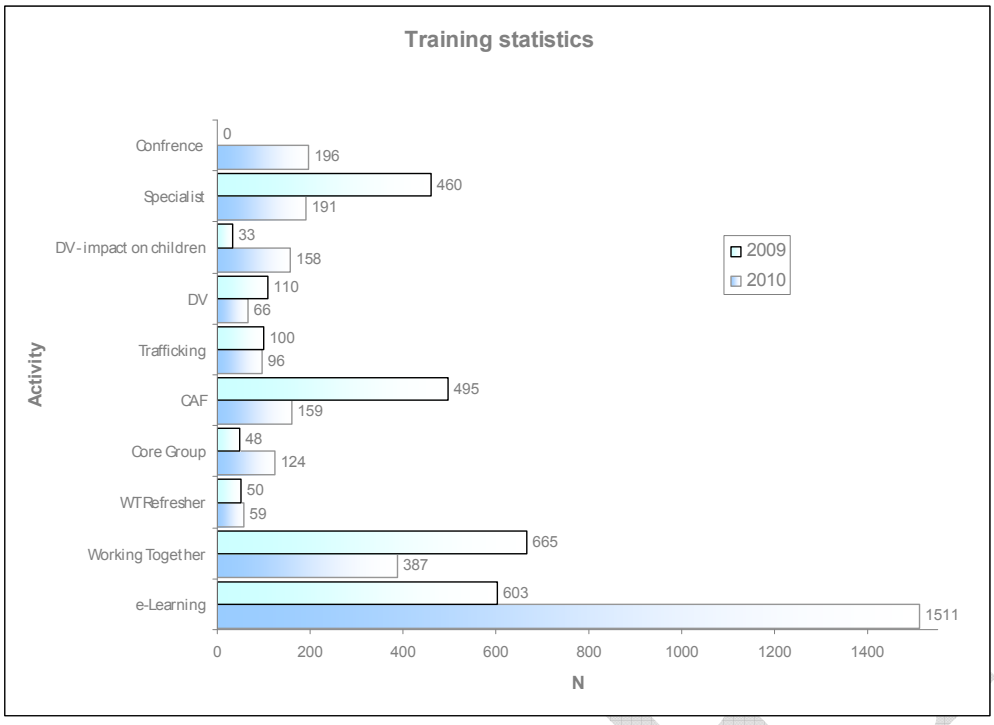
Regrettably, fewer practitioners have taken up the opportunity to attend multi-agency *Working Together* training which has slipped from 665 to 387 participants, nearly 42%. This tendency was partly expected because the previous year's figure was unusually high after the death of Baby Peter. Strict training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

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

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

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

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



Capacity

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

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

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

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

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

Allegations

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

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

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

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

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

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

HOW WE ARE DOING: effectiveness of local safeguarding

How the LSCB monitors local safeguarding arrangements

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

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

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

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

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

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

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

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

Effectiveness of local arrangements to safeguard children

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

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

The YOS Core Case Inspection took place between 25th and 28th July 2011 led by Her Majesty's Inspectorate for Probation (HMIP). The inspection

included an evaluation on how effective the YOS is in safeguarding and identified that substantial improvement was required.

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

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

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

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

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

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

registration. Improvement plans were drawn up by the C&EY Service and regularly monitored for compliance. Nationally 15% of all actions from childcare inspections were in relation to safeguarding and welfare.

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

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

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

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

Trafficking

The three tier model for combating child trafficking has been commended by the Home Office, and included in the National Strategy published in July 2011. This model includes fortnightly operational meetings identify children who may be at risk of trafficking or going missing. By this mechanism the total number of children who went missing has been reduced considerably from 24 to 8 during the year

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

Private fostering

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

privately fostered in the UK].The LSCB in Hillingdon will continue to raise awareness about this key safeguarding issue.

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

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

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

Recent national figures reveal an alarming increase in the number of children under 18 providing care within their family. In 1996 it was estimated that there were 51,000 young carers. This has now nearly tripled to 149,000. The real figure could be much higher as many families do not recognise the caring tasks that a child is taking on and therefore do not publicly acknowledge it. There continues to be a rise in the number of young carers in Hillingdon. There are currently 270 registered carers, which is a rise of 41 from the previous year.

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

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

All the identified actions from the Serious Case Review were completed by year end. There is anecdotal evidence that implementation has been carried

through into practice – improved identification indicated by increased referrals to LADO, procedures followed in strategy meetings, evidence from schools audit. Processes have been put in place to enable the LSCB to ensure that actions are fully embedded into local practice.

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

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

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

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

Potential risks to safeguarding

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

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

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

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

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

Potential opportunities to improve safeguarding

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

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

The Munro Review. If the Munro recommendations are implemented, the process of assessment should be more continuous and based on cumulative assessment of need, and the exercise of professional judgement, rather than being constrained by artificial timescales and targets.

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

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

NATIONAL AND LOCAL CONTEXT: implications for safeguarding

The Eileen Munro review of child protection.

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

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

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

National Health Service

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

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

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

Education changes

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

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

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

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

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

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

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

- The long term corrosive impact of abuse and neglect, particularly among adolescents, is not sufficiently recognised and addressed
- It is possible to provide validated programmes of help, but families often need longer term support to avoid breakdown or further damage
- Insufficient clarity among agencies over thresholds
- The benefits that can be achieved by proactive social work based on sound assessments and planning, and informed by knowledge of child development
- Evidence that families who fall below social care thresholds do not receive sufficient help, both before and after social care interventions. Close working between targeted services and GPs is needed

- There should be stronger links between those working in adult and children's services, particularly in respect of domestic violence, substance misuse and mental illness
- There have been improvements in inter-agency and inter-disciplinary working, some as a result of effective inter-agency training. There are concerns that proposed reforms to the NHS and schools and measures to restrict public spending might unintentionally have a negative impact on these advances.

WHAT WE NEED TO DO: priorities for LSCB 2011 onwards

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

Priority 1 Improve LSCB functioning

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

Priority 2 Assess and improve operational practice

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

Priority 3 Improve outcomes for children affected by key risk issues

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

Priority 4 Ensure a safe workforce

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

Priority 5 Learn from Case Reviews

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

RECOMMENDATIONS TO THE CHILDREN'S TRUST

Comment on needs assessment

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

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

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

Key messages

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

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

Very young children remain the most at risk group. However, SCRs and local experience reveal also a high level of need among adolescents and that is the

time when long term neglect becomes apparent, when problems are often most intractable and solutions outside the family less likely to work. Developmentally some problems that arise in the early years can be resolved in early adolescence, so a targeted approach to young people in or soon after transition from primary to secondary school is recommended. This should be included in the planning for early intervention services.

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

APPENDIX: LSCB membership 2010-11

Chairman and officers of the LSCB

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

Observers

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

Local authority representatives

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

Health representatives

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

- Chelvi Kukendra - Designated Doctor, Central North West London Trust
- Jenny Reid - Designated Nurse, Central North West London Trust
- Abbas Khakoo - Named Doctor, Hillingdon Hospital NHS Trust

Police and probation representatives

- Tariq Sarwar - Detective Chief Inspector, Hillingdon Borough Police
- Dave Franklin - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police
- Sharon Brookes - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
- Alison Jeffcott - Senior Probation Officer, London Probation

School representatives

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

Other representatives

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

QUALITY ASSURANCE AND AUDIT FRAMEWORK – CHILDREN'S SERVICES

Contact Officer: Merlin Joseph
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REASON FOR REPORT

This paper presents to the Policy Overview Committee for review and discussion audit findings using the Quality Audit framework for children's services.

OPTIONS OPEN TO THE COMMITTEE

1. To note and comment on the audit findings
2. To note and comment on the quality audit framework
3. To use the report to support Members in their scrutiny role.

INFORMATION

1. Across Social Care, Health and Housing (SCH&H), a quality assurance framework is being developed to co-ordinate and target activities to ensure robust scrutiny and underpin the delivery of quality services which improve outcomes for our residents who receive social care. The quality audit framework has been approved by the respective senior management teams in both children and adults social care, with the expectation that it will be evolved further through using it to provide reassurance about standards of practice; especially in the area of safeguarding adults and protection of children . The quality audit framework is included in this report as an appendix (Appendix 1).

2. The framework for SCH&H aims to:

    - Ensure that all service areas are able to demonstrate they are delivering quality services based on positive outcomes for customers.
    - Help develop high quality services which are responsive to the needs of local people.
    - Provide managers with a framework to assess performance and sustain service improvement using a wide range of audit information
    - Enable robust evidence of scrutiny and challenge against measurable standards and criteria.
    - Take account in children's service of the Munro review, which equates quality with improved outcomes, and a focus on the family's experience, and the child's journey through the system.

3. The framework has been developed to bring together different strands of challenge which help to drive improvement:

    - **Independent Challenge**
      Inspections and audits by regulatory bodies or external and partner agencies and national performance monitoring data.

- **Citizen Challenge**
  User and carer research and engagement through surveys, forums and complaints data.

- **Professional Challenge**
  Internal scrutiny including audits and reviews, staff supervision and appraisals.

SUGGESTED SCRUTINY ACTIVITY

1. Members question officers on the scope of the audits and how the results will be used to drive performance and quality in children's services.

Scope of Report

This is the quarterly report on case file auditing of children's social care records in both the family support service and children in care using the quality audit framework.

The audit tool, linked to the quality audit framework (Appendix 1B) was rolled out across child protection and family support services, and children-in-care in September 2011, but was tested by the safeguarding children and quality assurance team in July 2011 and August 2011. The audit tool was also used to audit a sample of cases in the Social Work Practice [SWP] pilot.

As a result of the test run, the management team in children and families took a decision to apply the principle that, if it isn't recorded, or otherwise evidenced on the Protocol, electronic case recording system then the event or practice would be deemed NOT to have happened. This decision was intentional to help build greater compliance with recording Integrated Children's System [ICS], and the integration of electronic social care records. The audit approach is robust to drive up and maintain high standards to safeguard children and young people.

In line with the quality audit framework, the service manager for family support, Parmjit Chahal, also conducted a themed audit on re-referrals from April 2011-October 2011, with support from an Independent Reviewing Officer [IRO].

Background

Performance Information

In September 2011, the results of the children in need [CIN] census for Hillingdon were published for the previous year April 2010-March 2011. This information showed that:

a. The number of referrals to Children's social care had risen for the fourth year in a row to 2814 [This was an increase of 500 on the previous year 2009-2010].

b. The number of children subject to child protection (CP) plans had remained the same as the previous year [2009-2010] at 232; but this is significantly higher than previous years 175 [2008-2009] 132 [2007-2008].
c. The activity around child protection work has increased with 213 children coming off a CP plan & during the year, and 217 children being made subject to a CP plan.
d. 350 More initial assessments were carried out during the year [total 2498] and 220 more core assessments were undertaken [871] during 2010-2011 than in previous years.
e. The number of children coming into care has declined [384] from the previous year partly due to the reduction in the numbers of asylum seeking young people arriving through the airport terminals.

The increased demand in child protection work, reflected in the children in need census for 2010-2011 has not diminished in recent months, and has continued at the same rate during the first half of the year [April-September 2011]. In addition, 30 new cases with one child or more have been escalated into the court process, since April 2011.

The impact of this demand has placed challenges on the current management team to ensure standards are maintained and raised where needed.

The audit period [July – October 2011] has seen improved stability in the ratio of permanent staff compared to agency staff. For example, the children in need team recently appointed a permanent team manager, after a prolonged period of time [almost 9 month without a manager being in that post].The new team manager is due to take up her position in the Child in Need (CIN) team by the end of November 2011. Also we have successfully recruited to the Emergency Duty Team manager post. [The successful applicant will need to give notice to the previous employer and will start in the New Year 2012.]

Despite these successes, one of the deputy managers in the children-in-care teams is still a locum member of staff, and one of the deputy team managers in the referral and assessment teams is a locum member of staff. In addition, one of the deputy team managers in the CIN team is on long term sick leave. These are all key posts which affect the quality of supervision and oversight of complex cases for social workers.

Referral and Assessment /Children-in-Need

In this period [July-October 2011], the service manager for referral and assessment and children-in-need conducted 60 audits of case files within this service, focussing largely on children subject to child protection plans. The service manager and the deputy director, observed child protection case conferences and met families on several of these cases to try and capture the experience of the families in their interface with the child protection system.

It was apparent from the audit work undertaken that the transfer of cases within services was not as clear and transparent as it might be, and therefore work has been commissioned on refreshing the transfer protocols. These are potential areas of delay in which families and other professionals can be unclear about how the service will be provided to them. Also the referral and assessment (RAT) managers have been asked to introduce more stringent audits of cases that are moving to other teams to ensure that the key documents are there; especially case conference reports, chronologies and where appropriate child-protection plans.

Standard 1	Is there an up too date chronology on file?	Of the cases being transferred out of RAT, 85% of the cases had a chronology, but not always up-to-date. Most of the chronologies did not include all the re-referral information. Standard was partially-met
Standard 2	Where child is deemed a child in need but not on CP plan or looked after or care leaver, is there a child in need plan in place which is up to date and kept under review?	Child protection plans were on file in 100% of cases but sometimes incomplete, to be firmed up by the core group. More detail is needed in most of the plan, but the overall decision-making has been evidenced in the majority of cases Standard was partially-met
Standard 3	Are statutory requirements being met? If not are reasons identified? *If statutory requirements are persistently unmet case should be rated as inadequate*	The initial child protection conferences (ICPC) were being held in a timely way in 98% of cases, where applicable. Recommendations are evidence based to a limited extent. More detail is needed in the case conference reports, and more family based assessments needed. Standard met.
Standard 4	Have Court/Panel filing dates been met? If not are reasons identified.	Several cases in children-in-need team show legal proceedings being considered, and or started but with some minor delays. An area for

		development is around the communication with families about the proposed action. Standard met.
Standard 5	Is the plan up to date and clearly focused on the child's needs and any risk of harm? Is there a clear picture of the child's needs, any risks and the actions being taken to meet needs and reduce risks? Is there a proper focus on health and education?	Core assessments, and CP plans were in place in the majority of cases. In most cases the analysis needed to be strengthened and aligned with the risks. Standard partially-met
Standard 6	If child is looked after is there: 1. an up to date Personal Education Plan [PEP] 2. a current health assessment [HAP]? 3. a current Strengths & Difficulties Questionnaire?	In most cases the children were not looked after, but in those cases which were being put through PLO or Court etc, education and health issues were being actively considered. Standard met.
Standard 7	Are ethnicity, religion and culture taken into account in assessment and work with the child and family?	The assessments on file could have benefited from exploring this area more fully, and were not sufficiently inclusive. However, there were some good examples of these factors being included in the social work practice in the case notes. Standard partially met.
Standard 8	Is the work with the parents/carers focused on the child's needs and their improving their capacity to meet those needs? Are the day to day and longer term risks being adequately addressed? If child on CP plan comment on the quality of the core groups.	Core group minutes were present on most cases The quality of the Core Group minutes were not detailed enough and in some cases not reflective of the plan in place. The involvement of parents and young people is evident on most cases but not consistently recorded. Standard partially met.
Standard 9	Where the main risk to a child is outside the home or extra familial – e.g. involvement in gangs, sexual exploitation or a	Issues of children being reported missing, as a risk factor is now being included more consistently

	trafficked child, is the plan likely to reduce the risk of harm?	on case files. Standard met.
Standard 10	If the child is looked after, is there a focus on working with and supporting the carers to meet the child's needs and improve outcomes? If the child is at risk – e.g. running away, involved in risky behaviours, is this being addressed proactively?	N/A
Standard 11	Are the reasons for any changes to the care plan clearly identified? Are changes soundly based on a thorough assessment of the child's needs and the best ways of meeting them?	N/A
Standard 12	Comment on the frequency and quality of supervision.	There is evidence of the manager having read the initial assessments and the endorsement of the recommendations made at case conferences, in almost all the cases. Supervision is clearly taking place in most cases on a regular basis, but the evidencing of this on Protocol ICS is not consistent. There are several examples of paper records being kept independently of ICS, and references to supervision being made in Protocol.
Standard 13	Changes of social worker.	In 20% of cases there has been some delay in cases being transferred from RAT to CIN due to capacity issues in CIN, Information provided to families and other professionals is not consistent. In most cases, changes of social worker had occurred only due to the case transfer.

Standard 14	Summary Areas of strengths / Areas for development	Strengths In most cases there was evidence of purposeful activity in relation to child protection reports, case conferences and CP plans, with some sound assessment being overseen by managers. Areas for development include better evidencing of decision –making, more transparency about case transfers, more detail in the assessments and case conference reports, and better recording of supervision.

Children-in-Care team audits

The following table is a summary of the findings from audits across the children-in-care casework records from July-.October 2011. During this period 100 case files were audited including the sixteen plus team; and 6 cases were audited within the children with disabilities team.

Standard 1	Is there an up too date chronology on file?	Many of the cases (55%) had chronologies but not all were on the ICS system. The majority were Court chronologies. The quality was satisfactory but some needed updating. Standard partially met.
Standard 2	Where child is deemed a child in need but not on CP plan or looked after or care leaver, is there a child in need plan in place which is up to date and kept under review?	This was applicable in 8 cases [including sixteen plus] and there was evidence that the CIN plans were time limited and up-to date but not being consistently reviewed for the effectiveness of the plan. [A bigger sample is

		needed before drawing any significant conclusions]. Standard partially met.
Standard 3	Are statutory requirements being met? If not are reasons identified? *If statutory requirements are persistently unmet case should be rated as inadequate*	In most cases the statutory requirements were met, or partially-met. However in 20 cases (20%) there was evidence of statutory visits taking place, but either not yet recorded or there was not enough detail recorded, or not recorded in the correct place on the system.
Standard 4	Have Court/Panel filing dates been met? If not are reasons identified.	In 57% of the cases this was not applicable as there were no care proceedings. In the remaining 43% of cases the court and panel filing dates had been met or partially-met. There was drift in one case which was due to the extended family's late application to court. Standard partially met.
Standard 5	Is the plan up to date and clearly focused on the child's needs and any risk of harm? Is there a clear picture of the child's needs, any risks and the actions being taken to meet needs and reduce risks? Is there a proper focus on health and education?	All had a care plan or a pathway plan but 50% of them were not fully updated, or did not contain enough detail or analysis. Standard partially met.
Standard 6	If child is looked after is there: 1. an up to date Personal Education Plan PEP 2. a current health assessment [ap]? 3. a current Strengths & Difficulties Questionnaire [sdq]. *Yes or no to each question will suffice but please comment on quality if it is either poor or good.*	In the cases where applicable (81) there was 71% with up to date PEPs etc. 55 cases needed Health Assessments to be updated and 60% needed SDQs to be updated. There was evidence from the case notes

		that there had been activity by social worker in relation to these issues, but this had not resulted in the plans being formally updated on the system. Standard partially met.
Standard 7	Are ethnicity, religion and culture taken into account in assessment and work with the child and family? *Some supporting evidence should be provided to back up your judgement*	In all cases there was satisfactory evidence of the ethnic, religious and cultural needs of the child being taken into account and addressed in care plans and pathway plans. But in most cases the evidence for this could have been more detailed. Standard partially met.
Standard 8	Is the work with the parents/carers focused on the child's needs and their improving their capacity to meet those needs? Are the day to day and longer term risks being adequately addressed? If child on CP plan comment on the quality of the core groups.	There is evidence on all files that the work with parents is focussed on the child's needs and the longer term plans re reducing risks. Standard met.
Standard 9	Where the main risk to a child is outside the home or extra familial – e.g. Involvement in gangs, sexual exploitation or a trafficked child, is the plan likely to reduce the risk of harm?	This applied in 50% of the cases and there was some evidence in the care and pathway plans that strategies were in place or discussed to attempt to reduce the harm. In most cases the quality of the evidence needed some improvement. Standard partially met.
Standard 10	If the child is looked after, is there a focus on working with and supporting the carers to meet the child's needs and improve outcomes? If the child is at risk – e.g. running away, involved in risky behaviours, is this being addressed proactively?	There was evidence of support for the carers in all cases were applicable. Some young people were in semi/independent living and the support was being provided by the social workers. The quality of the risk

		assessments for children who go missing needed improvement in most cases, and needed to be more readily referenced on the files. Standard partially met.
Standard 11	Are the reasons for any changes to the care plan clearly identified? Are changes soundly based on a thorough assessment of the child's needs and the best ways of meeting them?	In all cases, where applicable, the reasons for changes were evidenced in the case recordings, but were not recorded consistently in the documentation used for statutory reviews. There were often delays in updating the care plans; often just before a review instead of after a review. Standard met.
Standard 12	Comment on the frequency and quality of supervision. *It is especially important here to ensure supervision is addressing the plan for the child and focussing on reducing harm and improving positive outcomes*	There was evidence that in all cases that supervision discussions had taken place regularly [reflected in case notes, and 1-1 PADA recordings] but in 39% of the files the supervision was not recorded on ICS. Standard partially met.
Standard 13	Changes of social worker. *There is a correlation with 'drift' and looked after children particularly are adversely affected by social worker turnover and changes.*	There was no direct correlation between the number of workers and drift in care planning apart from one case where the young person had 3 workers in the space of a year. This was partly due to the transfer between teams. Some young people have had the same worker consistently for over 2 yrs.

		Standard partially met.
Rating Summary	Can you give an overall rating (met, partially-met or not-met)	In 15% of cases the standards were fully met. In 70% of cases, the standards were partially-met. In 15% of cases the standards were not met, and needed remedial action. These areas for improvement have been identified in the summary below.

Safeguarding Children & Quality Assurance Service Audits

Since 4th July 2011, 96 cases have been audited by the Safeguarding Children & Quality Assurance Service (SC&QA). The audits were carried out by the Independent Reviewing Officers [IROs] using the new quality audit framework. Of these cases 32 were done as a trial run of the audit tool in July 2011, and 80% of the cases audited were children in care. The aim is for the safeguarding and quality assurance service to provide an added layer of scrutiny and independence to the audits being undertaken routinely by operational managers within their respective services.

The quality practice audit tool (Appendix 1B) sets out the quality standards against which cases are monitored. Below is a summary of the findings of IRO audits against each standard.

Standard 1	Is there an up to date chronology on file?	Chronologies were found on 80% of the cases, but 1/3 of these were not fully up-to-date and of these most were deemed to have entries that were of variable quality. Standard partially met.
Standard 2	Where child is deemed a child in need but not on CP plan or looked after or care leaver, is there a child in need plan in place which is up to date and kept under review?	There were no cases that fall into this category audited. Cases which come to the attention of IROs are either children in care or subject to CP plans or both.
Standard 3	Are statutory requirements being met? If not are reasons identified? *If statutory requirements are persistently unmet case should be rated as inadequate*	In 50 % of cases statutory requirements were being met. There were 22 cases where statutory visiting requirements had been partially-met, or poorly recorded. 26 cases

		had assessments or reviews held outside of timescales, children being moved without reviews being held and care plans/pathway plans not being drawn up in a timely way. Standard partially met.
Standard 4	Have Court/Panel filing dates been met? If not are reasons identified.	There were no cases identified where court/panel filing dates had not been met but 2 cases were identified as being at risk of drifting. Standard met.
Standard 5	Is the plan up to date and clearly focused on the child's needs and any risk of harm? Is there a clear picture of the child's needs, any risks and the actions being taken to meet needs and reduce risks? Is there a proper focus on health and education?	There were 11 cases where care plans and/or pathway plans were either not submitted, non existent or out of date. All CP plans were assessed as satisfactory or better. Standard partially met.
Standard 6	If child is looked after is there: 1. an up to date Personal Education Plan [pep] 2. a current health assessment [hap]? 3. a current Strengths Difficulties Questionnaire [sdq]	Up to date PEPs were missing in 8 cases Up to date HAP were missing in 12 cases SDQ were missing in 13 cases. Standard partially met.
Standard 7	Are ethnicity, religion and culture taken into account in assessment and work with the child and family?	There were 7 cases where there was no evidence identified to suggest that these issues had been taken fully into consideration? Standard partially met.
Standard 8	Is the work with the parents/carers focused on the child's needs and their improving their capacity to meet those needs? Are the day	In most cases the standard was met or partially-met. Of those looked after there were 3 cases identified

	to day and longer term risks being adequately addressed? If child on CP plan comment on the quality of the core groups.	where little or no work was being undertaken with parents/carers. [The standard was not met]. Of those on CP plans core groups had not met with full attendance in 2 cases.
Standard 9	Where the main risk to a child is outside the home or extra familial – e.g. Involvement in gangs, sexual exploitation or a trafficked child, is the plan likely to reduce the risk of harm?	In 4 cases concerns were raised about continued risk to children who were looked after. These risks include absconding, substance misuse, sexual exploitation and gang related issues. In 1 case a SW was commended for facilitating effective therapeutic services (CBT) to address risk (fire setting). Standard partially met.
Standard 10	If the child is looked after, is there a focus on working with and supporting the carers to meet the child's needs and improve outcomes? If the child is at risk – e.g. running away, involved in risky behaviours, is this being addressed proactively?	In most cases the standard was met or partially-met. In 1 case there was no evidence of work to support carers. In 2 cases comments were made about high quality of carer but minimal input coming from SW In 1 case it was identified that the carer could not meet the YPs needs. In 2 cases praise was given for high quality of foster carer In 1 case recognition given to good care in residential setting.
Standard 11	Are the reasons for any changes to the care plan clearly identified? Are changes soundly based on a thorough assessment of the child's	In most cases the standard was met or partially-met. In 5 cases concerns were raised that

	needs and the best ways of meeting them?	decisions made were not as a result of a detailed assessment. In 5 cases changes to care plan had not been recorded after the review.
Standard 12	Comment on the frequency and quality of supervision.	In 21 cases supervision was assessed as either too infrequent or not evidenced as robust enough. In 12 of these cases there had been either no supervision recorded at all on protocol, or less than 3 sessions in the past 12 months. Standard partially met.
Standard 13	Changes of social worker.	In 8 cases there had been no changes of social worker. The most frequent recorded was 3 in 3 months. The most ever was 5 social workers. There is one case currently allocated to a manager due to frequent changes in SW in the recent past. Standard partially met.
Rating	Can you give an overall rating (met, partially-met, not-met)	64 cases were deemed to have met the standards. 20 were rated as partially-met 12 were rated as standards not-met

Social Work Practice [SWP]

The social work practice [SWP] has case responsibility for a cohort of 77 children-in-care in which London Borough of Hillingdon has corporate parenting responsibility.

Of this cohort, 11 cases were independently audited by an Independent Reviewing Officer [IRO] from the safeguarding children and quality assurance service, using the new auditing format. The cases were randomly selected from cases that were due to have a statutory review within the following 2 weeks. The file was audited for the last year i.e., a few months after allocation to SWP.

As there were relatively few audits done the findings will be summarised without using the table.

- Care plans: 4 out of 11 cases had satisfactory care plans because they reflected an assessment of the child's needs and indicated a plan for a way forward. Those that were deemed unsatisfactory generally did not provide a good enough account of the child's needs did not identify actions required, timescales and who is responsible. The majority of the care plans had not been updated, nor contained inaccurate information, or reflected a 'copy and paste' from older care plans (this in itself is not a problem- it is the updating and making the care plan current that was lacking).

- Statutory visits: there were 2 cases where there was clear evidence of regular visits to the child (minimum standard 6 weekly visiting). There were some write ups of visits that did not read like a visit to a child but were counted as a statutory visit at a minimal level for purposes of this audit. There was at least 1 case with a write-up of a statutory visit that seemed to be "a copy and paste" of the minutes of a child-in-care statutory review; and another where there was apparently no visit but a statutory visit is recorded on the case file. Based on the evidence of the ICS electronic case files, it appears that most of the children and young people had not been visited at a satisfactory frequency i.e. within the statutory minimum timescales of six weekly.

- Chronologies: there were no up-to-date chronologies in this cohort of cases. Where chronologies did exist, they were mostly out of date by several years. Some chronologies were an aggregate of data merged from different sources and therefore unsatisfactory as a chronology in that they contained indeterminate information. When it became known that the SWP were keeping a separate folder for their client files, under staff names, these were also perused in subsequent audits, but did not reveal case chronologies at all that were fit for purpose.

- Child-in-care health assessments: 8 children from this cohort had up to date health assessments. This reflects a concerted effort by the SWP to meet this aspect of the care planning, although not reaching a 100% target.

- Personal Education Plans [PEP]: 8 children from this cohort had a current PEP. Again, although not reaching a 100% target, this appears to reflect a concerted effort by the SWP to raise standards.

- Ethnicity, religion and culture: 3 of the 11 cases reflected more than just a scant, superficial consideration of this aspect of the child's life. The other 8 cases contained some information but it wasn't integrated into the care plan.

- Change of Social Workers: 8 cases out of the 11 have remained allocated to the same social worker since case responsibility was handed over to SWP. This does not take into account two Social Workers who went on long term absences from the job. The case records show that in the period of these absences there was no active social work involvement with these children.

- Analysis: 2 cases were deemed satisfactory in that they met the basic core requirements for a child in care. The remaining cases from this cohort did not meet the standards. The minimum standard looked for within the audits were for 'good enough' practice rather than the excellent practice that it was envisaged SWPs would aspire to, as part of the pilot.

Themed audit on re-referrals

One of the key elements of the quality audit framework is to undertake a program of themed audits to help improve the quality of practice. In this audit period (July-October 2011), a themed audit focussing on re-referrals has been undertaken jointly by the service manager for family support and referral and assessment, alongside an IRO from the safeguarding children and quality assurance service. This theme was chosen in conjunction with the Local Safeguarding Children Board, because partner agencies expressed concern about it, as being a possible issue for children repeatedly being referred for a statutory service.

There were a total of 276 re-referrals in the Referral and Assessment team in the period April-October 2011. A random sample of 125 re-referrals was examined in greater depth.

The audits focussed mainly on qualitative analysis to generate themes for improving practice, but also attempted to identify the concerns/issues first leading to a referral being made, the decision to close the referral and the reasons for re-referral. The safeguarding children and quality assurance service undertook a large percentage of these audits to enable greater objectivity [75 out of the 125 audits].

Analysis & themes from audit of re-referrals

General

- Seventy six cases of re-referrals of children had more than 4 referrals on the system. However, 30% of these had referrals cutover from the old Carefirst system, and would have been designated as "contacts" on Protocol.
- In the judgement of the auditors it appears that approximately 60% of cases were dealt with appropriately. In some cases the referral was diverted to other services. In some cases an initial assessment [IA] was completed and case closed after relevant discussions with the family and in a small number of cases, a core assessment had been completed and the case had been closed after a time limited piece of work.

Domestic Violence & Chronic Neglect

- Forty percent of these audited cases, were chronic neglect and /or domestic violence cases, which had repeat referrals, most of which were dealt with through an initial assessment. In some of these cases the auditors felt that the repeat nature of chronic neglect or domestic violence should have triggered a child protection enquiry.
- Many of these re-referrals were made within a short space of time, which should have been an added warning to address the concern through either a core assessment or a child protection enquiry.

- Some of these cases have subsequently come back into the system as tier 3 cases, where child protection plans have been implemented, 2 children had come into the care system. Hence the earlier referrals may have been a missed opportunity.
- Many of the cases did not have chronologies which were up to-date, appropriately recorded and easy to read by a Social Worker completing an assessment of a re-referred family.
- The majority of the re-referrals were about children between the ages of 4 and 10 years, which emphasised the need for early intervention.
- It also appears that some Initial Assessments undertaken by social workers were not connecting the re-referrals made for similar issues or general neglect/domestic violence .This meant that the presenting problem was being assessed in isolation rather than considering the holistic picture of the family, parenting and the individual child's needs. Therefore, it appears that managers were inadvertently signing off some incomplete initial assessments that may not be based on the full history of the family.

Mobile families

- Another issue arising from the audit were re-referrals that had been associated with families on the move. Often in these cases, the assessments had not always gathered the relevant information from other Local Authorities; so the initial assessment had been based on information provided by the family within Hillingdon.
- Where Hillingdon had been contacted for information on families that had moved out of the area, detailed chronologies, up to-date information and a detailed assessment were often not fully available on file.

Pre-birth assessments

- There was some evidence that pre-birth referrals were being made early in pregnancy. These cases were then closed due to the expected date of delivery (EDD) not being within three months at point of referral. This is a factor which had contributed to the re-referral rate. Case closure in these cases was probably appropriate and there were internal mechanisms in place to track such cases.
- Whilst infants were adequately safeguarded an assessment at an earlier point in some cases would have lead to improved case planning and partnership working. This would be particularly relevant to those referrals where there had been significant historical concerns, and the need for safeguarding measures to be in place prior to birth.

Relationship with partner agencies

- Feedback from referrers in partner agencies made via the Local Safeguarding Children Board [LSCB] had highlighted gaps in communication; especially regarding feedback following a contact to children's social care. The audit found that whilst referrers were contacted during the course of an assessment they were not necessarily routinely provided with a copy of the completed assessment and details of outcomes, including referral to tier 2 support services.

Re-referrals & Chronologies

- The issue of chronologies has been covered in the comments above regarding domestic violence and initial assessments. It was also an issue raised by the service manager, Parmjit Chahal, in the report for the Policy Overview Committee (POC) at the start of the year. Chronologies continued as an issue in this themed audit.
- Chronologies needed to be completed in a consistent way and would have assisted in the risk assessment process.
- In some cases where chronologies were completed they were of a variable quality and therefore did not assist the decision-making.
- The chronologies being 'pulled through' from case notes on the electronic file had often resulted in the chronology lacking emphasis on significant events.
- There was evidence of duplication of information resulting in paper and electronic files being used. At the current time it is not possible to obtain all the information held about a child from one source, although this has improved significantly since the last audit; and will be further improved by the introduction of the CIVICA Program.

Areas for Development and actions taken

In response to all the audits a number of areas for development were identified. These will continue to be discussed in the managers' meetings at both senior and operational level, along with actions to be taken to address them.

Chronologies

Though there had been some improvement in the usage of chronologies since the audit undertaken at the start of 2011, it remained a significant issue across all the audits from referral and assessment to child in need, children-in-care and the social work practice**.** This was further confirmed by the audits undertaken by the safeguarding children & quality assurance service. The service manager for family support services, Parmjit Chahal has taken direct responsibility for mentoring front line managers and practitioners about what constitutes a good chronology through the "Practice PODS" set-up in the child-in-need team. Workload relief is being given to allow managers and their supervisees to get chronologies up-to-date. Also a checklist has been put in place for referral and assessment team managers, to ensure that no case file is transferred to other teams in children's services without an up-to-date chronology being part of the child's record.

The safeguarding children and quality assurance service has been assisting with the focus on chronologies through their link role with each of the operational teams, and identifying where cases may need remedial action in terms of missing chronologies.

Quality of child protection plans and care plans

In most cases audited there was usually either a child protection plan, or a care plan in place on file if the child was in care. However, the quality of the plans was variable, and not detailed enough.

Managers have been briefed on this finding, and have been asked to give more attention in supervision to the quality of child protection plans and care plans. The Independent Reviewing Officers have been asked by the deputy director at their business planning day [7th October 2011] to be more challenging of the quality of these plans at both case conferences and statutory reviews.

The LSCB has developed core group guidance which focuses on the effectiveness of the child protection plan, and multi-agency training is now being delivered, which includes social workers and their managers

Similarly, the learning and development teams have organized additional training for social workers and managers on care planning and improving quality in compliance with the new regulations.

It has been agreed that care plans will be updated routinely, immediately after a statutory review so that it does not drift between reviews. The Independent Reviewing Officers, have been asked to follow up between reviews to check that the care plans are updated in this way.

Transfer Protocols

It was apparent from the audit work undertaken that the transfer of cases within services was not as clear and transparent as it might be, and therefore work has been commissioned on refreshing the transfer protocols. These 'transfer windows' are potential areas of delay in which families and other professionals can be less clear about how the service will be provided to them. Also the referral and assessment team managers have been asked to introduce more stringent audits of cases that are transferring to other teams to ensure that the key documents are there; especially case conference reports, chronologies and where appropriate child-protection plans.

Statutory Visits

A significant area of concern arising from the audits within the child protection arena, and in relation to children in care, was the inconsistent recording of social work visits demonstrating that children had been seen alone. The deputy director met with all the divisional managers in September 2011 to clarify the expectations around children being visited to re-set the standard of children being seen alone for safeguarding purposes.

Based on the discussions with managers, it was apparent that children had been visited and seen, but not always seen alone at the required frequency. It was also apparent that the recording for visits was often being made in the case notes, but not in the correct location on the ICS system. This made it difficult to run proper management reports for scrutinizing this activity.

A template has been drawn up to aid managers and practitioners in their recording of statutory visits, which demonstrates that children are being seen alone, and that there is a clear focus on safeguarding the child or young person.

This issue will continue to be scrutinized by means of future case audits, and by running regular reports from ICS for managers to identify where statutory visits are not being recorded.

Pre-birth assessments

All pre-birth referrals will be subject to an initial assessment at point of referral where deemed appropriate. Where historical concerns indicate significant concerns the case will be transferred to the children in need team at an earlier point prior to birth, following the completion of a core assessment, and where necessary initial child protection conference. This will ensure robust plans are in place prior to birth and enable a better seamless transfer of the case at an earlier point. It should be noted that some cases already transfer directly into CIC where care proceedings are to be initiated at birth. The RAT & CIC teams operate an early warning system in relation to these cases and it is currently working well.

Thresholds and levels of need

Significant work has been undertaken on developing a comprehensive threshold document with partner agencies. The views of stakeholders and partner agencies were sought and incorporated into the final document, before it was rolled out earlier in the year (2011). [See Appendix 2] .There is a commitment to strengthening partnership links which in turn will enable greater transparency and clarity in regards to thresholds for referrals. It is apparent from discussions with partner agencies that further work needs to be undertaken to integrate and evaluate the use of the threshold document through the Hillingdon Children's Trust Board as well as the LSCB.

There are now systems in place to ensure formal feedback is given to the referrer in a timely way at each point a decision is made. For example:

- Each referrer receives written notification of the outcome of their initial contact. This includes details of the decision made in regards to what action is to be taken i.e. no further action, sign posting to other agency, initial assessment or a section 47 investigation.

- On completion of an assessment the referrer is notified of the outcome and sent a copy of the assessment where there is parental agreement

Recording of supervision

One of the key drivers for improving standards of practice is the availability of reflective supervision for both front line managers and practitioners. The case file audits showed that the recording of supervision on both ICS, and paper based supervision files, was variable. This has been raised with the managers at a recent divisional management meeting, and at local management meetings.

The requirement for recording supervision on ICS to enable proper management reports to be run has been reiterated. In addition, a separate audit tool has been devised to enable service managers to routinely audit the regularity and the quality of supervision.

Fortnightly reflective practice seminars have been initiated for all new staff in the referral and assessment teams and the child-in-need team. These were set up by the service managers with involvement from the safeguarding children and quality assurance service. A key element of these seminars is to enable 'active learning' from different sources including serious case reviews. The importance of chronologies has been a consistent theme. It is intended that these seminars will become multi-disciplinary drawing, on the skills of local partners including: Health, Education, Probation and Police.

Evidence based practice

The audits noted that whilst most cases had an assessment [initial or core] ; often it was not up-to-date, and was not detailed enough, and contained insufficient analysis. Management decisions were not generally well-evidenced

The deputy director has commissioned Dr David Lawlor from the Tavistock clinic to deliver a program of support and training for managers on the use of reflective supervision. It is expected that this will begin to improve the practice of supervision and make a difference to the quality of work done with the children and families who use the child protection and care system.

The corporate parenting board also organized a recent conference [7th October 2011] on promoting the health of children in care; with briefings for practitioners on how to complete meaningful health assessments, and how to use the strengths and difficulties questionnaire to improve the emotional well-being of looked after children. In addition to this the Clinical Psychologist for LAC has run a number of training sessions on SDQ and improving self esteem of LAC.

Protocol ICS compliance

Overall, the audits done in this period (July-October 2011) showed that there is increasing compliance with the use of electronic files although significant difficulties continue to occur through recording information in the wrong place, and using case notes as a "catch-all" location for recording information. The move towards the electronic file being the only source of information for each child is being accelerated by the introduction of the 'Civica Programme', which will facilitate better scanning of paper documents, and linking to the child's record on protocol.

An emerging issue which came up in the audits was the quality of case conference reports, and the difficulty of undertaking assessments on ICS with multi-sibling families. In some cases the assessment was done on one of the siblings, and then the other assessments of siblings were left incomplete, though it was apparent that the work had been done.

This issue of needing to do family based reports on protocol has been formally raised with the provider company, liquid logic. The company has now developed a family assessment module, which will be purchased and rolled out in the New Year 2012. Hillingdon has also nominated an IRO to represent the social work teams at the USER GROUP meetings of Liquid Logic to ensure that protocol is evolved by social work practitioners rather than simply IT experts.

Social Work Practice (SWP)

The audits undertaken in the social work practice revealed the difficulties of exercising corporate responsibilities for this cohort of children at arms length from the Local Authority. To enable closer scrutiny of the work of the Social Work Practice, and to improve standards, an IRO has been seconded to the SWP for two days per week. The aim of this secondment is to support SWP and ensure that ICS is used more consistently to evidence their direct work with children in care.

Future plans

The quality audit framework will be extended to include audits from the youth offending service and the children with disabilities team. [These teams currently do audits, which are not easily merged into the format above, but do still cover similar issues]. It is expected that by the time of the next report to the Policy Overview Committee in March 2012, there will be more performance information available from these teams

The overarching challenge will be to better capture the experience of the child's journey through the system. The audits carried out to date, have picked up themes and issues that undoubtedly impact on the child's journey, but there has been a significant focus on improving the case recordings and the compliance with the ICS system. Service Managers and the Deputy Director have started to do their own direct observations of practice as part of the audit framework, and have met families and young people as part of the programme. The aim will be to do more of this kind of direct observation.

Other themed audits will be undertaken over the next few months to include a focus on the quality of child protection plans, as well an audit of the decision-making in child protection enquiries; especially those enquiries that do not proceed to a case conference.

APPENDIX 1

London Borough of Hillingdon

Policy and Procedure for Quality Assurance Audits Social Care, Health and Housing

1. Introduction

This policy outlines the strategic approach to managing the quality assurance of performance across adults and children's services. The council has well established mechanisms for evaluating performance and driving improvement in social care with good ratings achieved in both adult and children's services.

Hillingdon children's services have an established auditing framework, together with routine collection of national and local performance indicators. In addition the Local Safeguarding Children Board (LSCB) has a well established monitoring framework for overseeing progress or otherwise in making improvements in response to serious case reviews, case audits and any other identified areas of concern. Audits are collated and reported to members on a regular quarterly cycle and monthly reports on performance across a number of areas including staff vacancies go to the Children's Social Care, Service Managers meetings (SMT).

A great deal of information is therefore collected for different audiences already but there is scope for development. For example, although elected members get regular reports including the outcomes of audits, the audit framework is based on standards with each standard scored as *fully met, partially met* or *unmet*. This does not translate easily into current Ofsted scoring for social work and safeguarding services where the judgements range from inadequate to outstanding on a four point scale. The previous framework consisted only of audit reports completed in line management with the consequent risks of subjectivity and overly positive findings.

Common principles apply to adults and children's services. These include the importance of using performance indicators together with individual audit and casework quality measures to manage services and improve overall performance. Minimising risk, improving outcomes and ensuring value for money are priorities for the council and the department. However, it is recognised that there are some differences and there is therefore a separate indicator set and audit tool proposed for children's and adult social care services. It is vitally important that any audit framework focuses on outcomes; and the experiences of service users, as well as traditional key performance indicators.

2. Aim and Purpose

Audits are designed to ensure managers and elected members are equipped with the knowledge they need about performance across social care services for children. It should:

- identify areas of strong performance
- as well as areas that need attention
- should be sufficiently robust to identify improvements and any areas of decline.

Audits should also be used as a benchmarking tool whereby the council can compare performance with other similar councils; and also capture the qualitative experience of service users.

3. Scope

The following services are fully included at this stage:

- Children's Social Care teams – Referral and Assessment, Children in Need, Looked after children, Children with Disabilities, Sixteen plus, the Asylum Service.
- Social Work Practice pilot
- Targeted Youth Support Service

- Older Peoples' social work
- Mental Health Social Work
- Learning Disability social work

The following teams are not included in the new audit framework at this stage.

- Fostering and Adoption teams
- Children's Homes
- Youth Justice service

This is either because they have their own inspection and reporting frameworks which the current auditing arrangements capture, or in the case of Intensive Family Support, the work should be reviewed as part of the overall casework with the family. The current audit arrangements will remain in place and be reviewed at timescales of 6 months/12 months in the year. Performance data will be reported as part of the overall data reports, on a monthly basis via the rag rated scorecard.

Other areas not in scope at present include:
- Short breaks for disabled children (this will be reviewed independently)
- Home care services

4. The New Quality Assurance Framework

The new framework is based on the principles in the Quality Assurance Framework recently developed by Local Government Improvement and Development Board and the London Safeguarding Children (LSCB). This has been developed as a framework for LSCBs but it adapts easily for use by Children's Social Care services.

http://www.idea.gov.uk/idk/aio/25409798

The framework will bring together three types of information –

- quantitative (mainly performance indicators and data as in Appendix 1A),
- qualitative (which will include audits using Appendix 1B for children's social care)
- information about outcomes for children (see Appendix 1A).

The set of performance data in Appendix 1A will be reported to:
- elected members,
- the LSCB, Children's Trust, (LSCB) (HCFT)
- Corporate Management Team, (CMT)
- Departmental Service Management Team (SMT)
- Children's Services Divisional Management Team. (DMT)

An audit format for children in need, child protection and looked after children is attached in Annex B. The format is designed to capture the key qualitative information on case holding social work records. It should be used with children with disabilities where there is an allocated social worker and similarly with young asylum seekers who are looked after or otherwise children in need. There will continue to be a need for an additional audit tool for Youth Offending services.

4.1 Quantitative data

Children's services already have a structured reporting of performance data. The monthly performance report is a comprehensive set of performance indicators and useful data. It is reported to the children's Senior Management Team (SMT). It enables the SMT as a whole to track performance and to enquire into areas where performance may be dipping.

As well as including the national indicators and comparisons with statistical neighbours, the report addresses other key management information including vacancy rates broken down on a team by team basis, assessments on a team by team basis and a wealth of information about looked after children's education.

The core data set includes a section on 'Workforce and Workload' with vacancy information team by team. This should be a regular item for SMT as there are considerable variations ranging from no vacancies in some teams to over 50% in another team. The workload statistics are useful on a team basis for SMT, elected members and other forums but should also be considered on a child per worker and family per worker basis, by service managers and team managers. Frequency of supervision should be reported on a team by team basis, and the audit framework will attempt to capture supervision quality.

The above information is consistent with the recommendations of the Munro review, which focuses on the child's journey through Children's Services, and is based on systems analysis.

4.2 Qualitative data

There is a sound basis for audit in Hillingdon. Managers routinely audit within their own services and the Safeguarding Children & Quality Assurance Service undertake independent audits. The LSCB has also commissioned multi-agency audits.

The Safeguarding Children & Quality Assurance Service will take on an enhanced role in overseeing the routine audits that will be taking place within line management. This will include ensuring the audits are taking place, that they are proportionate to risk and that all social workers are included over each six month period

5. Guiding Principles for Audits.

The following guiding principles should be applied:

1. Proportionality. Audits should be proportionate to risk. Some services such as work with children on child protection plans or mental health social work, present high levels of risk to vulnerable individuals as well as reputational risk to the council. Other services will present financial risk (e.g. looked after children in residential care, children and adults with complex and challenging needs). Other services may pose lower risks but be high volume.
2. Effective auditing should involve line managers. In line audit should be undertaken as part of the line management function – it is an essential part of the line manager's repertoire of methods and skill. Managers should use audits as part of their overall management and supervision of teams and individuals.
3. Independent auditing is equally important. It should be undertaken by suitably experienced and skilled staff to ensure that there is a consistent check on the quality of work undertaken. It complements in line auditing and provides a check on the standards of line managers. It ensures consistency of approach and guards against complacency.

4. Regular audits should be complemented by themed audits which may arise from regular audits or other sources such as performance indicators, serious case reviews or agency concerns.

6. Expectations of Managers

It is expected that managers will use the outcomes of audit, together with performance indicators relating to their service area, to improve the quality of services, ensure value for money, and to focus on good outcomes for children and adults in receipt of services. It is also expected that managers should use audits plus performance indicators to assist in staff and team development and to tackle poor performance effectively at an early stage.

7. Audit Format

The new audit format is intended to capture risks to children as well as compliance with statutory requirements. It should give a good picture of the quality of the work. The format is reproduced in Appendix 1B and it prioritises the following:

- Were statutory requirements met and if not why not?
- Is there an up to date chronology on the file?
- Is the plan up to date and clearly focussed on addressing the needs of the child and any areas of risk of harm? Is there evidence that the social worker communicates well with the child and is there a clear picture of the child's needs and risks and action being taken to meet them? Is there a focus on health and education? Are race, religion and culture taken into account?
- Is the work with the parents and/or carers focussed on the child's needs and improving their capacity to meet those needs? Are the day to day risks in the child's home environment being adequately addressed where these exist (mainly Children in Need and Child Protection). With Child Protection are core groups effective - is there evidence of reducing risk?
- Where the main risk to children is outside the home or extra familial – e.g. involvement in gangs, sexual exploitation or trafficked children. Is the plan likely to reduce the risk of harm? If so, is it being implemented properly and is it being appropriately reviewed?
- Similarly with Looked After Children – is there a focus on working with carers to meet the child's needs and improving outcomes? If the child is at risk – e.g. running away, risky behaviour etc is this being addressed proactively
- Comment on the quality of supervision (and whether it is progressing the plan for the child)
- Is supervision reflective, with due consideration given to evidence based practice.
- Have there been any changes of social worker in the last year?

An overall grade will be allocated and at this stage the grading should use 'inadequate/adequate/good' with the possibility of introducing 'outstanding' at a later date once use of the new format is well established.

8. Procedure

- All managers at team manager level and above, including Independent Reviewing Officers to independently audit 3 cases on a monthly basis which should be randomly selected. This is a minimum standard. More audits should be undertaken if possible.

- Some Service areas (e.g. Referral & Assessment) would expect to undertake more audits by agreement with the Service Manager.

- Service managers should audit within their own service and use the findings together with the findings from off line audit (below), as the basis for improvement plans. Findings should be fed back into the service as a whole and to individual workers and managers through the individual audit report and face to face feedback where feasible.

- Team managers and deputy team managers to audit 3 cases a month in their own teams ensuring that they audit across the workforce. The service managers should line manage the process in consultation with the Safeguarding and Quality Assurance Service who have the lead role in ensuring a robust auditing system is in place and reported upon.

- Social workers should be encouraged to audit their own work using the audit tool, which can then be discussed in supervision. It is important that social workers feel part of this process of improving standards.

In Hillingdon, senior management up to the level of Chief Executive also audit cases via Protocol. There are many possible permutations but as there is a newly formed new management team, across Adults and Children's Social Care, and a wish to have a framework across the new Directorate, the departmental management team may wish to set aside some time to audit together as part of a regular timetabled session to look at casework quality. We would recommend that a senior management audit should include some random sampling of care plans, reviews and child protection plans, and reviews in children's services and a similar sample of plans in adult services.

9. Audit Schedule

Audits/Reports Schedule					
Type of Audit/Report	Completed by	Reports Presented to			Frequency
		SMT	**CMT**	**POC**	
Qualitative case file audits – 3 per worker	Team/Line Manager	√			Monthly
Qualitative random case file audits 4 per IRO	Independent Reviewing Officer /S&QA	√	√	√	SMT Monthly CMT and POC quarterly
Children's core data set/score cards	Data Analyst/Service Managers	√			Monthly
CIN,CP and LAC reports	Data Analyst/Service Managers /S&QA	√	√	√	SMT- Monthly CMT – quarterly POC - quarterly

Themed audits	Service Managers/SC&QA	√	√	√	As and when – annually
SC&QA report to accompany management information	SC&QA	√	√	√	Quarterly
Random selection of cases for audit	CMT/Chief Executive		√	√	Six monthly
End of service feedback from service users report	Team Managers/Service Managers	√	√	√	Annually

10. Implementation

A phased implementation is proposed with the children's audit tool in Appendix 1A, being used first in the Children's Social Care teams, the Social Work Practice pilot and the Targeted Youth Support service. This will commence in September 2011. The amended dataset for children at Appendix 1B will also commence from September 2011.

11. Monitoring/Evaluation

Compliance with the audit framework will be monitored by the Performance and Intelligence Service.

Given that there is less outcome data for CIN and CP services, the LSCB and SMT are committed to designing an end of service 'exit interview' based on whether the help given to service users had made a difference. This will be more useful if parents and children give permission for a further follow up phone call after a year. If in addition permission was given to follow up with a phone call to the child's school (or health visitor/children's centre for younger child), a reasonable assessment could be made about whether the intervention had made a positive and sustained difference. Over time this could be valuable data for developing, commissioning and decommissioning services.

Appendix 1A core dataset

National indicators

Health – all three are outcome indicators

- Prevalence of breastfeeding NI53
- Obesity in reception class NI55
- Emotional and behavioural health of looked after children(think this needs treating with caution as more subjective than previous indicators) NI58

Staying safe

- % of IAs in 10 days and Core assessments in 35 days NI 59 and 60
- Timeliness of placements for looked after children for adoption following agency decision that child should be placed for adoption NI61
- Stability of placements (number and duration indicators NI63 and 63)
- CP plans lasting 2 years or more NI64
- Percentage of children becoming subject of a CP plan for second time NI 65
- Looked after children reviewed within timescales NI66
- Percentage of CP cases reviewed within timescales

Education – all outcome indicators

- Secondary school persistent absence rate (could be a proxy outcome indicator)
- Looked after children receiving 5 A* -C at key stage 4 English and Maths NI101
- Young people from low income backgrounds progressing to higher education NI 106

Positive contribution – all outcome indicators

- First time entrants to youth justice system NI 110
- Under 18 conception rate NI 112
- Rate of permanent exclusions from school NI 114

Economic well being

- Care leavers not in education, employment or training
- Care leavers in suitable accommodation

Other indicators not currently NIs but collected

- Percentage of LAC who are adopted
- Vacancy rates by team
- Children missing from care
- Looked after children and young people who have an up to date personal education plan

New indicators

- Levels of staff sickness by team
- Frequency of supervision
- Timescales for care proceedings
- Frequency of announced and unannounced visits for children on CP plans
- Fostering recruitment activity data

New outcome indicators to be developed by LSCB and Children's Quality Assurance

- Views of children who have been subject to child protection plans on the effectiveness of help provided (to be sought through interviews with a sample of children and young people)
- Views of parents and carers on the help provided through child protection plans.

Appendix 1B – Children's Social Work audit framework

Children's Social Work Audit Form

Child's Name

Audited by

Date

1. Is there an up to date chronology on file? Comment on quality.
2. Where child is deemed a child in need but not on CP plan or looked after or care leaver, is there a child in need plan in place which is up to date and kept under review? *Comment on quality of plan and whether child's wishes and feelings are sought and whether plan is realistic and understood by parents/carers.* *Also where there is a support package in place for a child with disabilities or additional needs, or where parenting support is being offered comment on the likelihood of the additional support promoting a positive outcome for the child and minimising any risk of harm.*
3. Are statutory requirements being met? If not are reasons identified? *If statutory requirements are persistently unmet case should be rated as inadequate.*
4. Have Court/Panel filing dates been met? If not are reasons identified. *Drift in care proceedings is likely to have an adverse impact on the child. This will become a new performance indicator once baseline established across legal and children's services. Meanwhile audit should be used to help identify areas where practice can be improved.*
5. Is the plan up to date and clearly focused on the child's needs and any risk of harm? Is there a clear picture of the child's needs, any risks and the actions being taken to meet needs and reduce risks? Is there a proper focus on health and education? *This question applies to young people over 16 including care leavers. It also applies to children with disabilities in receipt of services from CWD.* *With care leavers auditors should ensure there is an up to date pathway plan which has clearly been drawn up with the young person and which is tailored to their needs. If it is the final review ensure that there is a clear support plan especially with education, training and employment.*
6. If child is looked after is there: 1. an up to date PEP and 2. a current health assessment? 3.a current SDQ *Yes or no to each question will suffice but please comment on quality if it is either poor or good.*

7. Are ethnicity, religion and culture taken into account in assessment and work with the child and family?
Some supporting evidence should be provided to back up your judgement

8. Is the work with the parents/carers focused on the child's needs and their improving their capacity to meet those needs? Are the day to day and longer term risks being adequately addressed? If child on CP plan comment on the quality of the core groups.

This section will mainly apply to CIN and CP but may also apply to some LAC.
For CP cases, the functioning of core groups should be commented on here

9. Where the main risk to a child is outside the home or extra familial – e.g. involvement in gangs, sexual exploitation or a trafficked child, is the plan likely to reduce the risk of harm?
Comment here whether the plan is appropriate and whether it is being implemented and reviewed as necessary and whether there is any evidence of reduction of harm Also with care leavers this section should be used to identify areas of risk and steps being taken to attempt to reduce harm

10. If the child is looked after, is there a focus on working with and supporting the carers to meet the child's needs and improve outcomes? If the child is at risk – e.g. running away, involved in risky behaviours, is this being addressed proactively?

11. Are the reasons for any changes to the care plan clearly identified? Are changes soundly based on a thorough assessment of the child's needs and the best ways of meeting them?
Care plans should be kept under constant review so changes are often appropriate. However, they should be well considered and there should be evidence of this in the records.

12. Comment on the frequency and quality of supervision.
It is especially important here to ensure supervision is addressing the plan for the child and focussing on reducing harm and improving positive outcomes

13. Changes of social worker.
There is a correlation with 'drift' and looked after children particularly are adversely affected by social worker turnover and changes.

14. Can you give an overall rating

An overall score should be given where possible – if you want to qualify it you can do so but please try and use the 3 point scale.

APPENDIX 2

Levels of need and thresholds for access to children's social care services in Hillingdon

Introduction: the case for agreed thresholds

One of the features of the best children's services as evaluated by Ofsted is that they should have agreed and understood thresholds for referral to social care. In the Chief Inspector's most recent Annual Report she states that:

> *Partnerships should define and agree thresholds for referral to social care – the level of concern which would make such a referral appropriate ……. Unannounced inspections have found that where there is a lack of clarity among partner agencies in relation to the threshold for referrals to social work teams, this can lead to a high percentage of referrals resulting in 'no further action'. In turn, this has an adverse impact on the ability of social work teams to complete assessments in a timely fashion. Inconsistent application of thresholds by managers across the referral and assessment teams also has an impact on the timeliness of assessments and on the rate of unnecessary re-referrals.*

Thresholds for access to children's social care are often seen as purely rationing mechanisms. However, effective thresholds should also promote referrals so that agencies know when to refer to social care. In a recent Ofsted report on serious case reviews: *Learning lessons from serious case reviews 2009-2010* it is stated that:

. *This concern about the application of thresholds was one of the findings from a review in which the parents had a history of substance misuse. The Local Safeguarding Children Board concluded that more immediate referrals to children's services and, in this particular case, to the community drug team would have enabled information-sharing, assessment and planning to be more effective. The Local Safeguarding Children Board identified differing views within the services about thresholds for referral. The review highlighted the need for work to ensure clarity across agencies about thresholds, including a shared understanding about the boundaries of family support and child protection, and the nature of the roles and responsibilities of key staff in the relevant services.*

The overall message from Hillingdon Safeguarding Board is that if there is any concern that a child may be at risk of serious harm, a referral should be made immediately and where possible it should be accompanied by a Common Assessment (CAF).

In all other cases the Common Assessment Framework (CAF) should be used to assess the child's needs and assess whether they can be met within universal services. Where there is any ambiguity about whether a child may reach the thresholds for social care, professionals can consult with the Referral and Assessment team for advice and assistance prior to making a referral. As well as advising whether thresholds are met, the team can signpost to preventative services

and assist with the CAF process.

Terminology

There is confusion about some of the terminology used in children's social care. Colleagues from partner agencies have also pointed out that there can be differences in the use of seemingly common terms across different local authorities. These are the definitions in current use in Hillingdon.

Thresholds – when applied to social care, thresholds describe a framework for deciding whether children are likely to be children in need as defined by the Children Act 1989 and whether the level of need is such that an assessment should be provided by social care rather than by other services through use of the Common Assessment Framework. Children at risk of significant harm are at the highest and most urgent level of need.

Child in need – the child is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority, his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or he is disabled.

Significant Harm- The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. Sometimes, a single traumatic event may constitute significant harm, such as a violent assault. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development.

Contacts and referrals – A contact is made when the Children's Services referral and assessment team is contacted about a child who may be a child in need, and where there is a request for information, advice or a service. At the point that the contact is made the duty worker will establish whether it can be dealt with by information, advice or signposting elsewhere.

All initial approaches to the referral and assessment team are deemed contacts in the first instance. A contact will be progressed to referral where the duty worker and manager consider an assessment and/or services may be required for a child in need.

Requesting an assessment or service – in most circumstances, requests for assessment and/or services from social care should be made via a common assessment (CAF). Exceptions to this are the Police who use their own Merlin/Form 78 form and acute hospital services who use a modified CAF. The exceptions are on the basis that both the hospital and the police often have a brief intervention with the child and /or family and are not be in a position to make an assessment over and above the actual incident leading to the contact.

Levels of need: threshold guidance for referrals to children's social care in Hillingdon

Most children achieve good outcomes with the help of their families alongside universal education and health services. Some children are vulnerable and at risk of poor outcomes. The factors that impact on this could be within their family, their environment or in themselves. These children need extra help, either to reduce the risk or increase the protective factors, or a combination of both. Some examples of Risk and Protective factors are described in the appendix.

When deciding which level of priority need a child or young person falls within, Hillingdon children's services will take into account the age of the child and the likely impact of the concern on the child's welfare and development. The purpose of any assessment is to identify the risks that make a child vulnerable, identify the protective factors that are present, and develop a plan with the aim of increasing resilience and reducing risks.

For a small group of children the identified risks are so many, or of such severity, that statutory services need to be involved. These children will include children at risk of significant harm, at risk of family breakdown, or at a serious risk to themselves or to others in the community. They will include all those identified below as meeting the criteria for Level 3 and a significant proportion of Level 2 Children in Need.

The following examples are not exhaustive and with the exception of the high priority need category, a single example will not necessarily trigger a specific response.

Level 1 Additional needs – may require a common assessment /lead professional response

This category includes children whose needs may not be consistently met, but where there are no acute risks. Children's social care services help is not essential and a social work assessment will not be required to access services. Other children's services may already be involved e.g. health visiting, educational welfare.
Where an assessment is required Hillingdon agencies use the Common Assessment Framework (CAF) to assess a child's additional needs and decide how these should be met. The CAF should be also be used by all agencies before contacting children's social care unless there are clear and urgent child protection concerns.

Areas of need	Additional needs which may need a multi-agency response or may need signposting or referral to services other than social care including parenting support services and community based services. *These are examples – other situations may fit this criteria*
Health	• Slow in reaching developmental milestones • Limited take up of universal health services • Children with some special needs/health needs(including mental health) requiring coordinated support
Education	• Children regularly absent from school or not reaching their potential educational targets • Children at risk of school exclusion or who have been excluded • Children with an educational statement who have broader needs than educational/developmental issues, requiring a more holistic assessment and a multi-agency response.
Social, Emotional, behavioural	• Children who have little opportunity to meet and play with other children, given their parents' isolation. Advice will be given on playgroups/after school clubs etc • Children involved in petty crime and who have received a final warning/reprimand • Early onset of sexual activity/ teenage pregnancy • Onset of low level substance abuse • Children suffering the impact of past domestic violence • Children occasionally reported as missing from home for short periods (not overnight)
Family and social relationships	• Children with challenging behaviour whose parents are unable to cope without the provision of services • Parents have relationship difficulties which may affect the child • Children who are young carers
Child's environment	• Homelessness or severe overcrowding • Family require support or advice in respect of harassment including racial harassment
Parental factors	• Parental substance misuse/offending behaviour impacting on child but below level of significant harm • Parents mental or physical health impacts on child but below significant harm • Children whose life chances are limited by parental poverty

Level 2 Child in need

A child in need will have identifiable factors, which indicate that considerable deterioration is likely without support. This will include children who have been 'high priority' in recent past (e.g. looked after or on a child protection plan). Children's social care referral and assessment service are likely to undertake an initial assessment and possibly a core assessment by a qualified social worker. Children who need ongoing support are likely to go on to receive specialist support services (e.g. Intensive Family Support or Targeted Youth Support Services). Some children may have some features, which indicate level 2 support but which are mitigated by protective factors. (See appendix).

Areas of need	**Child in need** *These are examples- other situations may fit this criteria*
Health	• Children living in an environment that poses a risk to their safety or well being • Children who self harm where parents are not responding appropriately • The physical care or supervision of the child is inadequate • Children with a high level of special needs or disability requiring constant supervision, which results in high risk of family breakdown
Education	• Child underachieving severely at school and not supported or encouraged by parents • Child's attendance at school is very poor because of parental neglect • Child has been excluded and is at risk of permanent exclusion and/or family breakdown
Social, emotional, and behavioural	• Children with challenging behaviour (including disabled children) whose parents are unable to cope without provision of services • Children who are often missing from home or have been missing for lengthy periods • Children who are firesetting and placing themselves or others at risk of harm • Children involved in offending behaviour leading to the involvement of courts
Family and social relationships	• Children under 16 who are privately fostered • Children where there is a risk of breakdown of relationships with parents/carers • Children experiencing several carers within their own family networks where there is inconsistency and insecurity for the child • Children exhibiting attachment disorders e.g. severe separation anxiety which impacts on their development

Child's environment	• Child lives in a family which is characterised by ongoing domestic violence or where there has been a history of domestic violence • Home environment or hygiene places the child at risk of significant harm
Parental factors	• Parent has a physical disability or history of mental health problems or learning disability which affects their ability to care for the child • Parent has a history of being poorly parented or looked after which is impacting on parenting their own child. • Parents whose criminal and /or anti-social behaviour threatens the welfare of the child • Parent has no effective family or community supports, or is victimised within their family or community with consequences for the child

Level 3 Children in need of protection

This is the most urgent category, which always requires a referral to children's social care. There will be serious concerns about the health, care or development of a child. It may include serious family dysfunction, a child beyond control or a child who has been severely rejected including abandonment. There will be a likelihood of a need for statutory intervention.

It will also include children with severe disabilities who need access to overnight care in either a foster home or residential child care provision and as a consequence are looked after children.

Areas of need	**Child in need of protection/safeguarding**
Health	• Situations where the physical care or supervision of a child is severely neglected • Pre-birth assessment indicates unborn child at risk of significant harm • Children where there is sufficient body of evidence to suggest there is a risk of FGM • Serious substance abuse • Children who seriously self harm including eating disorders
Education	• Chronic non attendance at school attributable to lack of parenting support
Social, emotional and behavioural	• Children with severely challenging behaviour, which results in serious risk to the child or others. • Children who are experiencing acute emotional rejection by parents/carers including unrealistic expectations, 'scapegoating' and seriously inconsistent parenting

Family and social relationships	• Child has suffered significant harm or is at risk of suffering significant harm through parental abuse • Child needs to be looked after outside own family because of immediate risk • History of previous concerns or past abuse that have not been effectively resolved • Child is running away because of abuse
Child's environment	• Child has been sexually exploited or trafficked or is at serious risk of exploitation • Home environment or hygiene places a child at risk of immediate harm • Child lives in an environment with a high level of violence • Child is in contact or association with unsafe adults
Parental factors	• Parent is suffering from severe physical or mental health problems or learning disability and is failing to adequately care for their child. • Both or only parent is involved in severe alcohol or substance abuse which is affecting the child's well being • Parent has a pre-disposition to violence and /or extreme anti-social behaviour • Parent/carer has a conviction against children or is known to have had a previous child removed under a court order

Appendix 2A

Risks and Protective factors

	Risk Factors	Protective factors
The child/young person		
Health	Birth problems – e.g. low weight, drug withdrawal Developmental delay Poor health Frequent attendance at A&E/hospital admissions Physical or learning disability Mental health problems Early sexual activity	Full term and normal birth Up to date with immunizations and dental checks Achieving developmental milestones
Emotional and social development	Isolated, sad or depressed Poor appetite Poor sleeping Being bullied or bullying others Engaging in crime or anti-social behaviour Few or no friends Early signs of physical aggression	Strong attachment to one or more significant adults Age appropriate and positive friendships Behaviour within normal range for age Sense of humour/easy temperament Good coping skills-optimism, problem solving
Parents/carers		
Basic care	Parents have mental health problems/depression Misuse drugs/alcohol Learning or physical disability Domestic violence Physical aggression to child Lack of basic care- food hygiene etc Young parent Isolated parent Parent unable to recognize particular or special needs of the child	Parent provides basic care – home, food, health care Parent protects from danger and harm Good ante-natal and post natal care Parents own problems don't get in the way of good care for the child
Emotional warmth and stability	Lack of routine in the home Inability to get child to school/health appointments etc Excessive control or punishment Over anxiety Lack of emotional warmth and encouragement Ongoing disputes within the	Stable and affectionate family relationships Parents show warmth, praise and encouragement Provide secure and consistent care

	family Family life prevents child from making friends or forming significant attachments	
Guidance and boundary setting	No appropriate role modeling Absence from school condoned/encouraged Lack of consistent boundaries and discipline Lack of appropriate monitoring and supervision Low level of interaction between parent and child	Parents provide appropriate guidance and boundaries to help child develop good behaviour and values Parents provide stimulation and play Parents interact appropriately with child Education, health care and achievement encouraged and supported Parents respond appropriately to concerns about their child
Environment		
Wider family	Family engaged in crime or anti-social behaviour Family isolated Lack of contact with extended family History of involvement with statutory services Loss of significant adult through death or separation Large family size	Child has strong relationships with wider family/siblings Family deals well with temporary stress factors Parental disputes have minimal impact on child
Physical	Homelessness Poor housing Unemployment Low income Frequent moves	Accommodation has basic amenities and is in reasonable condition Family manage income and employment issues to ensure minimal impact on child Reasonable income with resources used appropriately to meet child's needs

Community	Family not accessing universal or targeted services Family socially excluded Experiencing harassment or discrimination High levels of crime /violence/anti-social behaviour in the community Child involved with anti-social peer group	Appropriate services accessed within the community Family has positive friends and family networks Child has supportive and positive peer group Child attends appropriate leisure activities
School	Poor attendance Poor concentration Not functioning to level of ability Quiet and withdrawn Persistent poor behaviour Low expectations from teachers Excluded for temporary or permanent period	Child has good relationship with teachers School views child positively School supports child to achieve Child has strong friendship groups in school

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HILLINDON VIRTUAL SCHOOL UPDATE:
LOOKED AFTER CHILDREN ATTAINMENT REPORT, ACADEMIC YEAR 2010-11

Contact Officer: Fiona Lyon or Gregor O'Gorman
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REASON FOR ITEM

To meet the Committee's request for an update on the education progress of Looked After Children (LAC).

OPTIONS AVAILABLE TO THE COMMITTEE

The Committee may seek further information.

1. KEY STAGE 4 ATTAINMENT

- From 2005 to 2009, a higher percentage of Hillingdon LAC achieved 5 or more GCSEs than LAC nationally.
- From 2006 to 2008 the gap in attainment between Hillingdon LAC compared to all pupils in London Borough of Hillingdon Schools achieving 5 or more GCSEs closed gradually; and did so significantly in 2009.
- This gap widened again in 2010 (when we had a very high percentage of SEN and EAL pupils in Y11) and it was predicted to widen again for 2011. This is due to Hillingdon Schools' continued improvement against national attainment.
- When comparing the attainment gaps which exist between LAC nationally and Hillingdon LAC, since 2008 Hillingdon LAC have continuously achieved higher than the national average of all LAC. However, in 2010 there was a considerable closing of the gap and it is predicted in 2011 (based on the estimated average growth of 3% of LAC nationally achieving grades A* to C) that this will continue to close further.
- In 2010, and it is predicted for 2011 (based on the estimated average growth of 3.58% of all children achieving grades A* to C), that the attainment gaps which exists between all children and Hillingdon LAC has and will continue to broaden.
- Nationally the percentage of Statemented LAC is 29.8% (The national average for all other pupils being 3%).

When looking at 2010-11's KS4 GCSE attainment of Hillingdon's LAC:

- It is important to understand that 34.8% of the cohort, (over one third), had a statement of SEN.
- An additional 11.6% have English as an Additional Language (EAL).
- Therefore, 46.5%, (almost half), of the Hillingdon LAC were either unable to access the national curriculum or had it modified significantly in order to access it.
- It should also be held in mind that numbers of LAC vary year on year and the figures are very small, compared with a Year 11 school cohort. This significantly impact on percentage figures, which should be read with caution.

- Reporting only on GCSE results also significantly weights attainment reporting to a limited number of children and it should be noted that children with Statements attending special schools and those with EAL have gained relevant qualifications related to their potential or current ability.

At the end of academic year 2010/11, the London Borough of Hillingdon had 60 Looked After Children (LAC) in Year 11.

Table 1: Hillingdon LAC in Y11 at End of Academic Year 2010-11

Number of Students completing Yr 11	**60**
Of these:	
have a Statement of Special Educational Needs (SEN)	18 (30%)
have English as an Additional Language (EAL)	14 (23%)
Of the 60 pupils:	
sat at least 1 GCSE(or equivalent) examinations	38 (63%)
obtained at least 1 GCSE (or equivalent) at grade A* to G	37 (62%)
obtained at least 5 GCSEs (or equivalent) at grade A* to G	20 (33%)
obtained at least 5 GCSEs (or equivalent) at grade A* to C)	14 (23%)
obtained at least 5 GCSEs (or equivalent) at grade A* to C including English and Maths	8 (13%)

N.B.The same children appear in more than one category

1.1 SSDA903 RETURN

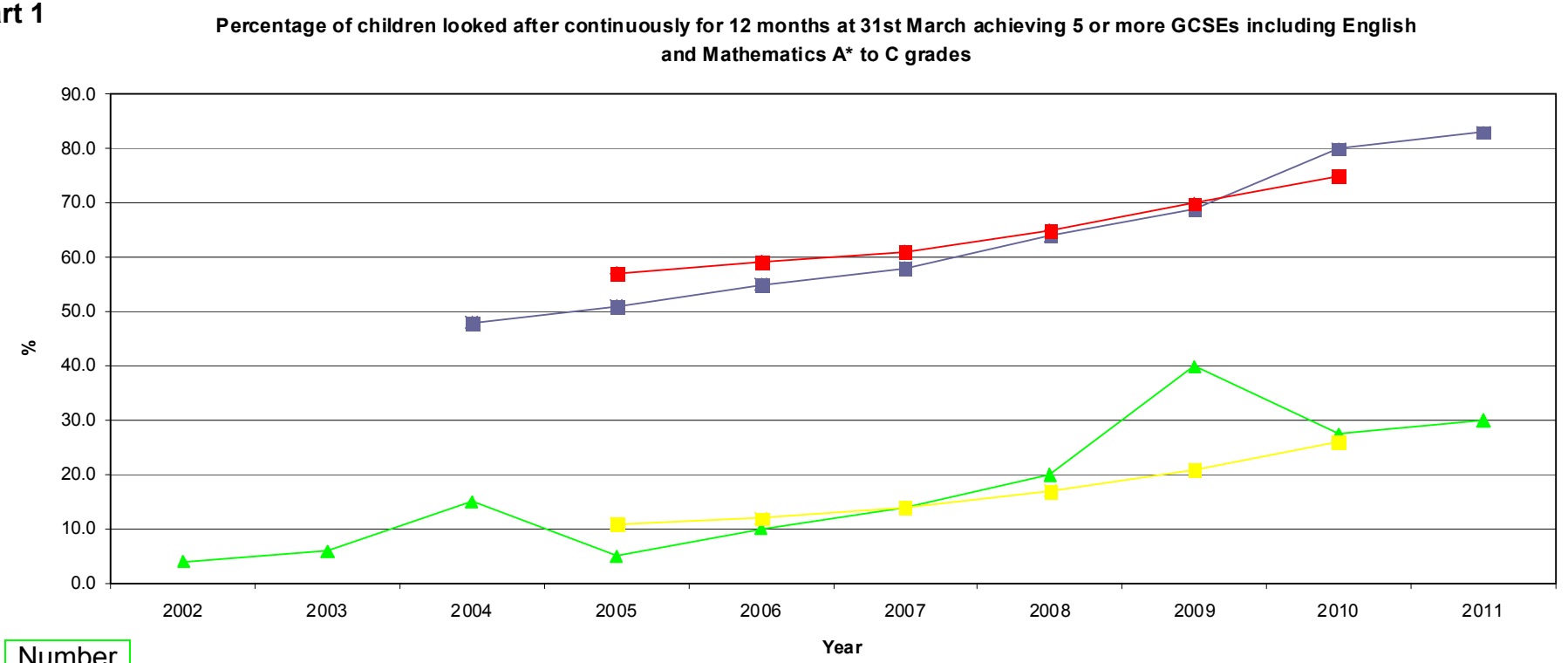
The SSDA903 Return requires us to only report on the attainment of those LAC who were in care continuously for 12 months; (April 2010 – March 2011), reducing the reporting figure from 60 to 43 LAC.

Table 2: SSDA903 Return - Hillingdon LAC in Y11 at End of Academic Year 2010-11

Number of Students completing Yr 11	**43**
Of these:	
have a Statement of Special Educational Needs (SEN)	15 (35%)
have English as an Additional Language (EAL)	5 (12%)
Of the 43 pupils:	
sat at least 1 GCSE(or equivalent) examinations	32 (74%)
obtained at least 1 GCSE (or equivalent) at grade A* to G	31 (72%)
obtained at least 5 GCSEs (or equivalent) at grade A* to G	17 (40%)
obtained at least 5 GCSEs (or equivalent) at grade A* to C)	13 (30%)
obtained at least 5 GCSEs (or equivalent) at grade A* to C including English and Maths	8 (19%)

N.B.The same children appear in more than one category

Chart 1



Number of LBH LAC	51	65	65	74	62	65	59	61	40	43

Key

All pupils

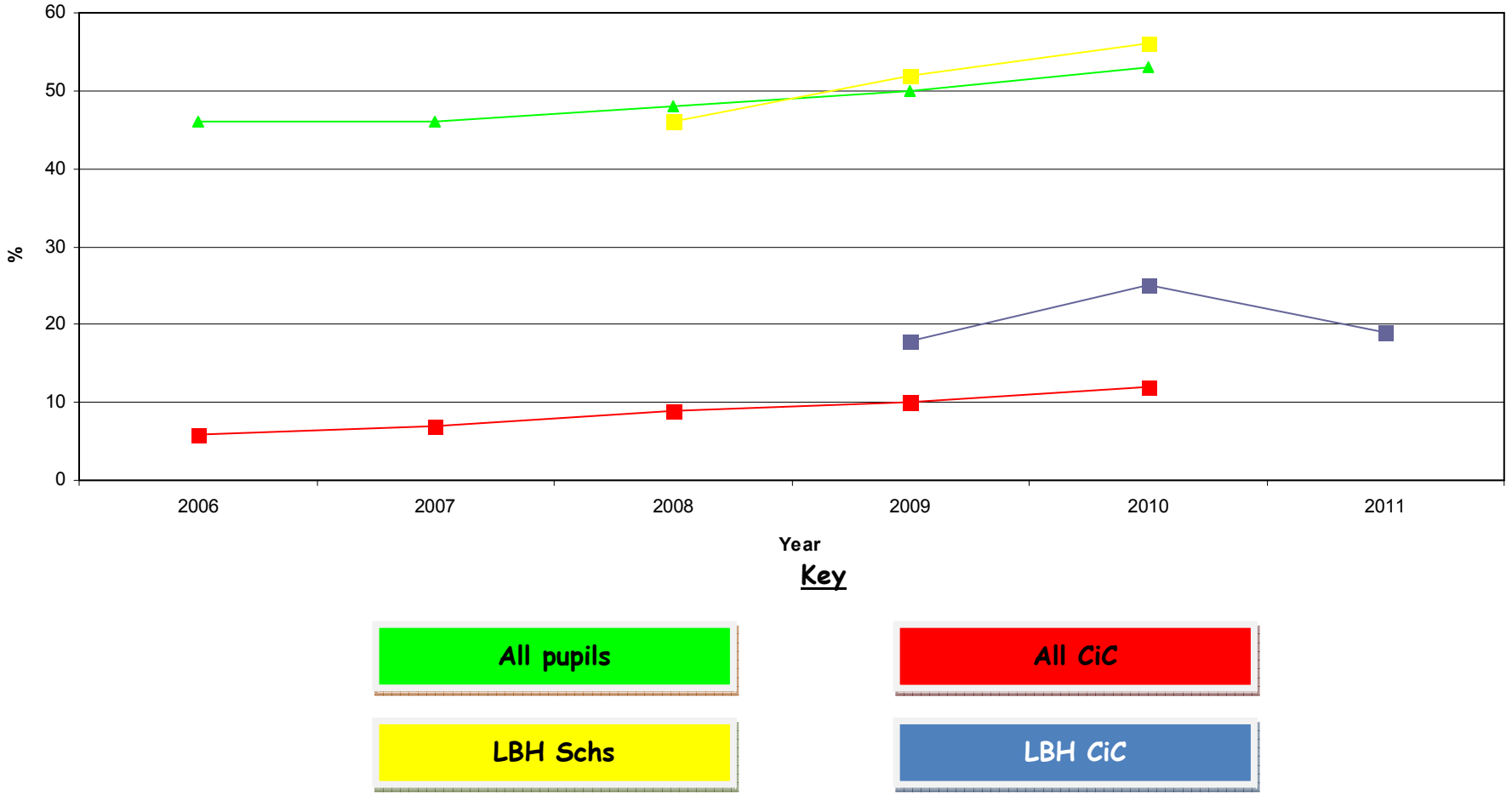
All CiC

LBH Schs

LBH CiC

Chart 2

Percentage of children looked after continuously for 12 months at 31st March achieving 5 or more GCSEs including English and Mathematics A* to C grades



2. KEY STAGE 2 ATTAINMENT

At the end of academic year 2010/11, the London Borough of Hillingdon had 10 Looked After Children (LAC) in Year 6.

Table 3 Looked After Children in Year 6, 2010/2011

Number of Students completing Yr 6	**10**
Of these: have Special Educational Needs (SEN)	5 (50%)
Of the 10 pupils:	
reached level 4 in English	4 (40%)
reached level 4 in Maths	4 (40%)
reached level 4 in English & Maths	3 (30%)

N.B.The same children appear in more than one category

2.1 SDA903 RETURN

The SSDA903 Return previously required us to only report on the attainment of those LAC who were in care continuously for 12 months; (April 2010 – March 2011), reducing the reporting figure from 10 to 8 LAC.

Since 2008 the percentage of London Borough of Hillingdon's children looked after continuously for 12 months achieving level 4 or higher in English has steadily increased and the gap which exists between all children and London Borough of Hillingdon's children who have been looked after continuously for 12 months has narrowed.

Since 2009 the percentage of London Borough of Hillingdon's children looked after continuously for 12 months achieving level 4 or higher in Maths has increased and the gap which exists between all children and London Borough of Hillingdon's children who have been looked after continuously for 12 months has narrowed.

2011 is the first year that the London Borough of Hillingdon's children who have been looked after continuously for 12 months have surpassed the national average for all looked after children.

Hillingdon Virtual School has focused on the early identification of AEN and SEN of pupils entering care and it is anticipated that this upward trend will therefore be maintained. This improvement will, over time also be evidenced in improving results at KS4 for those who remain in long term care and will also improve life chances for those LAC who move on to adoption or return home.

Table 4 SSDA903 Return - Looked After Children in Year 6

Number of Students completing Yr 6:	**8**
Of these:	
have a Statement of Special Educational Needs (SEN)	3 (38%)

Of the 8 pupils:

reached level 4 in English	4 (50%)
reached level 4 in Maths	4 (50%)
reached level 4 in English & Maths	3 (38%)

N.B.The same children appear in more than one category

Chart 3

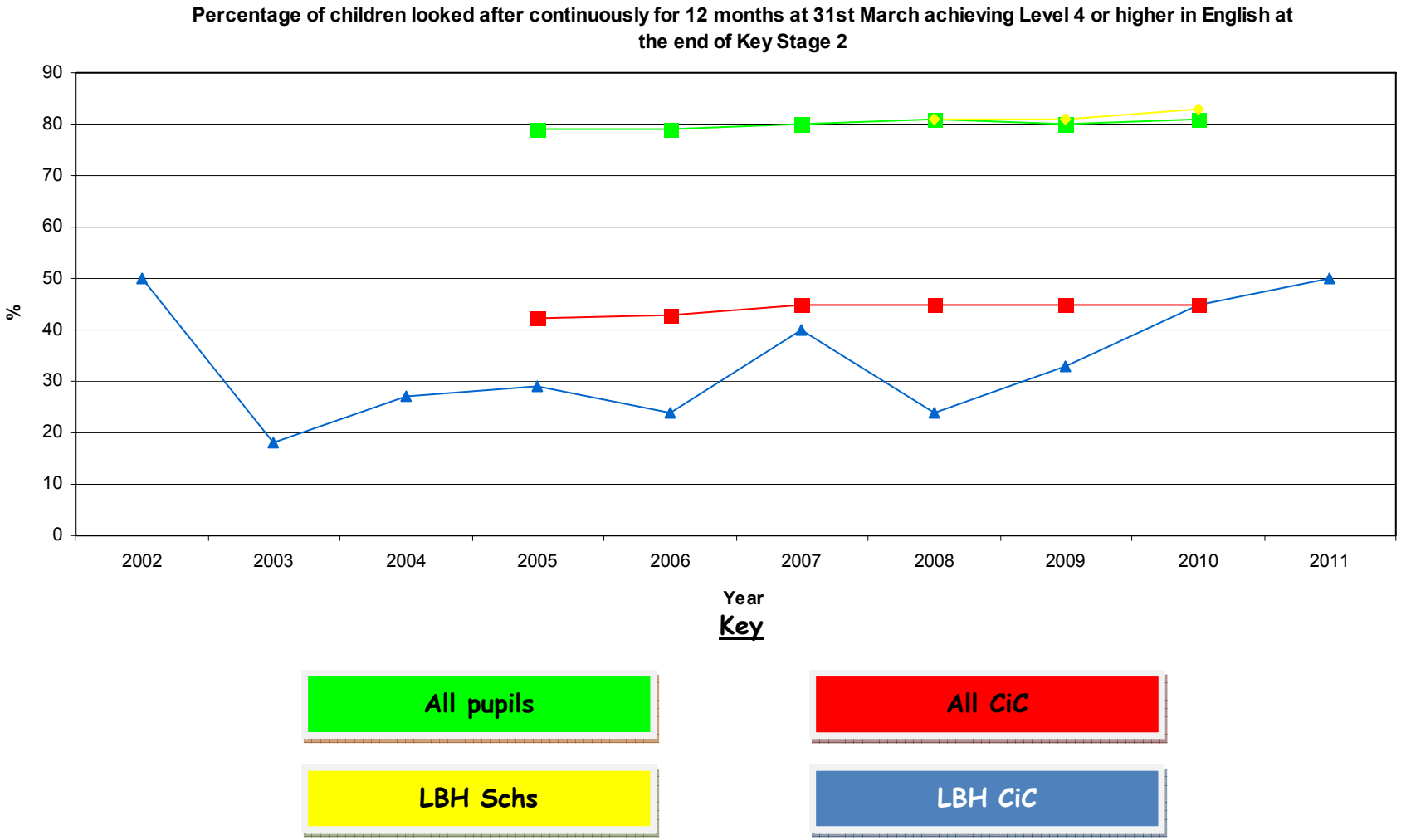

Percentage of children looked after continuously for 12 months at 31st March achieving Level 4 or higher in English at the end of Key Stage 2
90
80
70
60
50
40
30
20
10
0
%
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
Year
Key
All pupils
All CiC
LBH Schs
LBH CiC

Chart 4

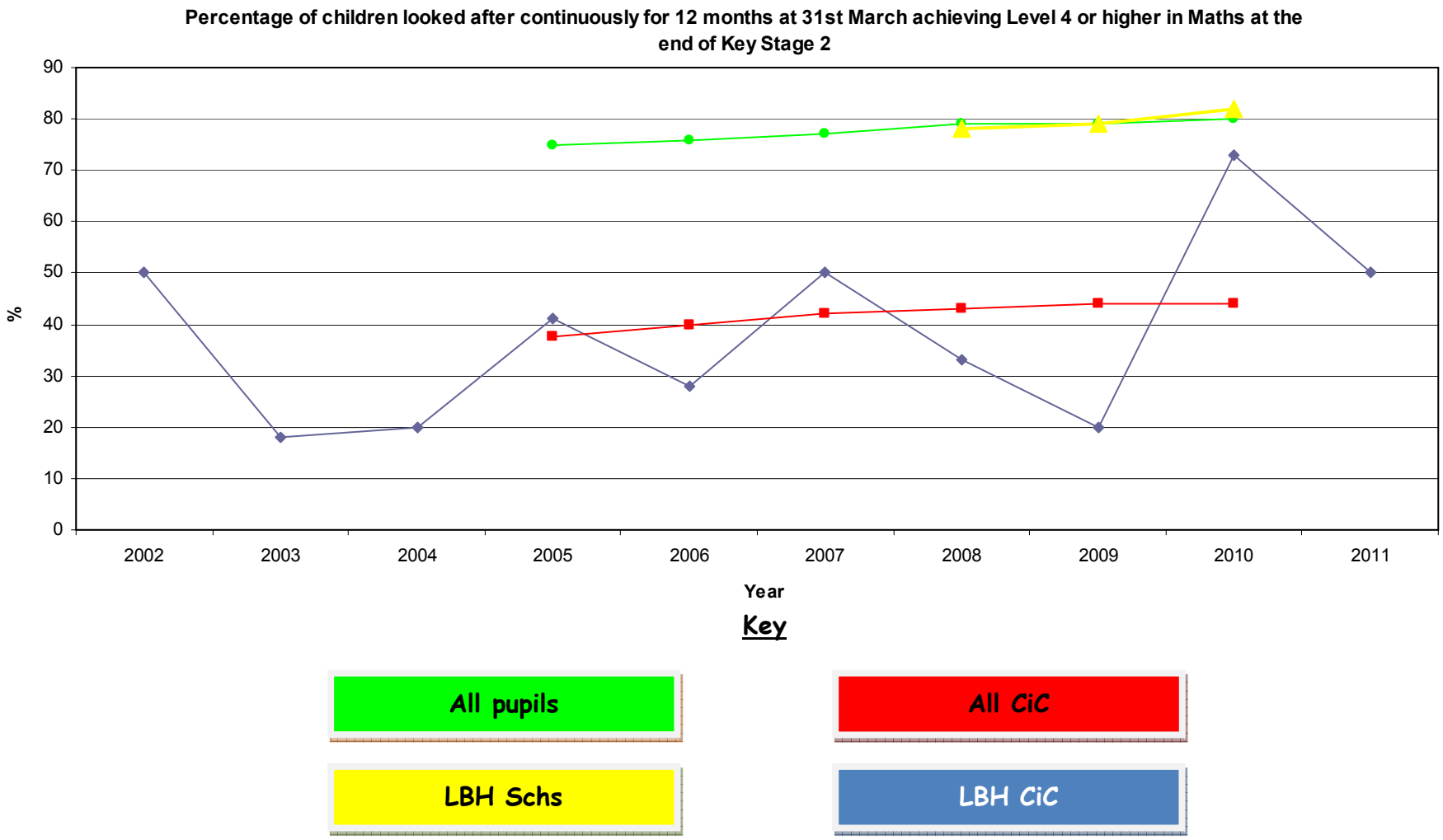
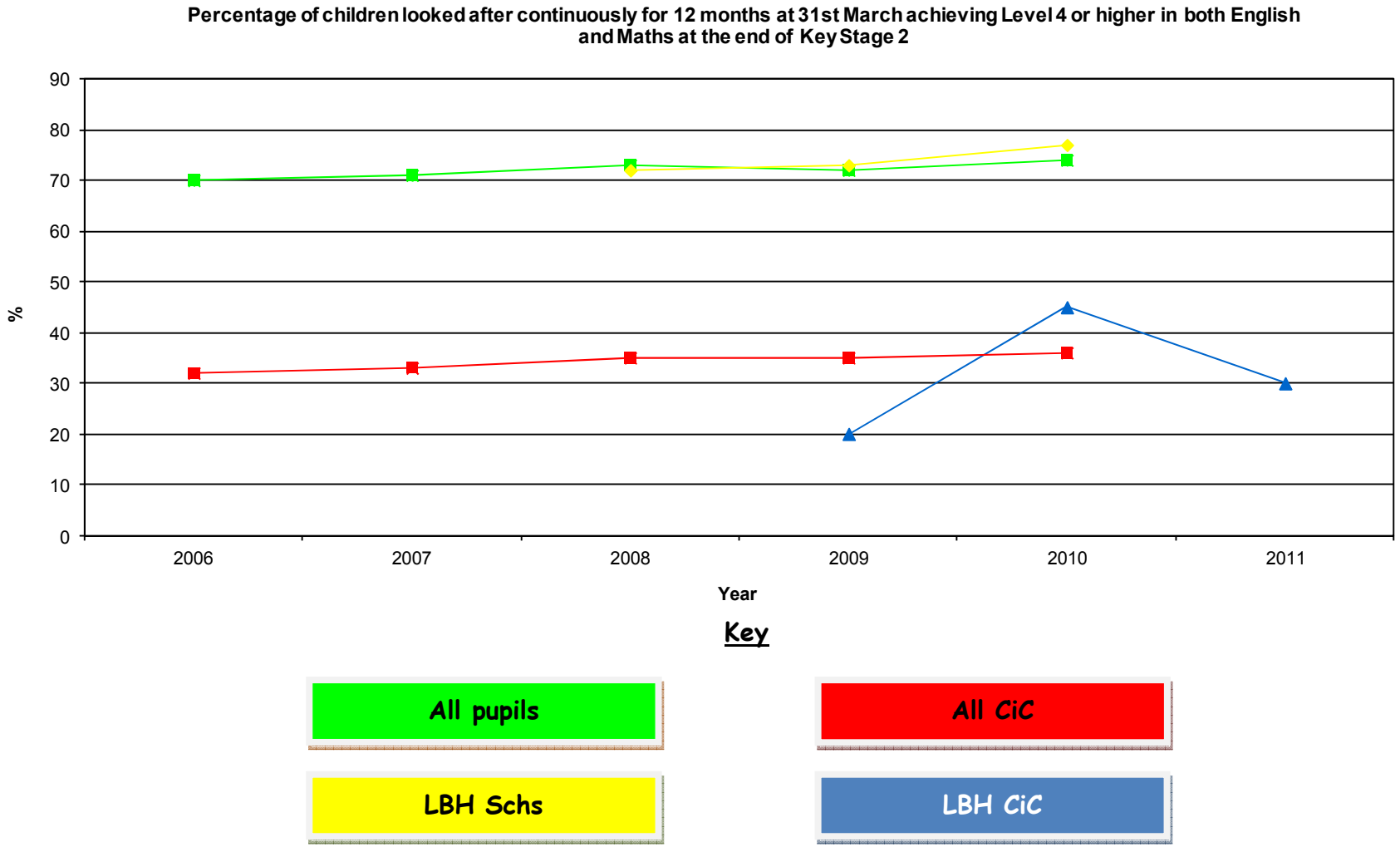

Percentage of children looked after continuously for 12 months at 31st March achieving Level 4 or higher in Maths at the end of Key Stage 2
90
80
70
60
50
40
30
20
10
0
%
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
Year
Key
All pupils
All CiC
LBH Schs
LBH CiC

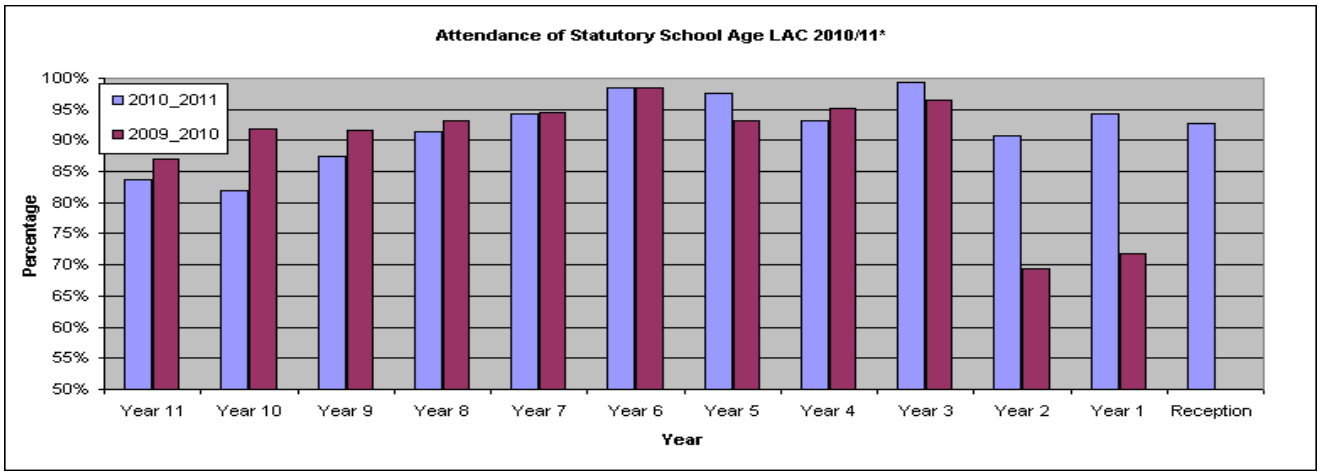
Chart 5


Percentage of children looked after continuously for 12 months at 31st March achieving Level 4 or higher in both English and Maths at the end of Key Stage 2
90
80
70
60
50
40
30
20
10
0
%
2006
2007
2008
2009
2010
2011
Year
Key
All pupils
All CiC
LBH Schs
LBH CiC

3.0 Attendance

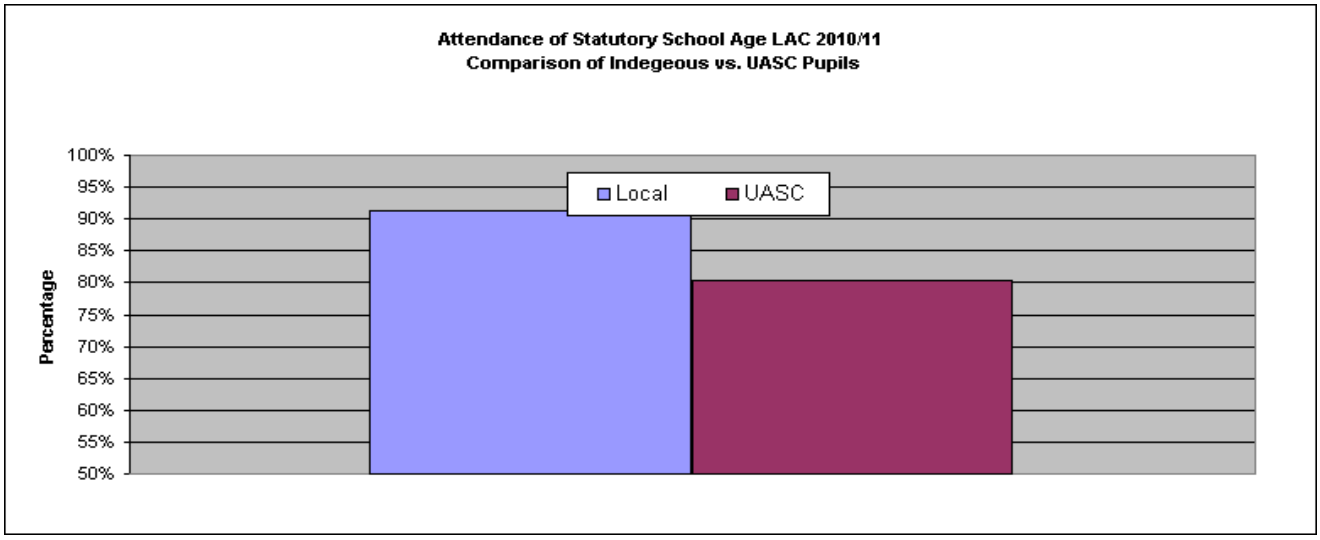
Attendance analysis shows a decline in attendance from 90.24% to 89.36%. This is a reflection of our monitoring now including those who are on part time timetable or alternative provisions such as UASC who access part time ESOL provisions. This is also reflected in the charts below.

Chart 6



*Comparison of year group cohort over a 2 year period i.e. Yr11 2010/11 vs. Yr10 2009/10

Chart 7



4.0 Exclusions

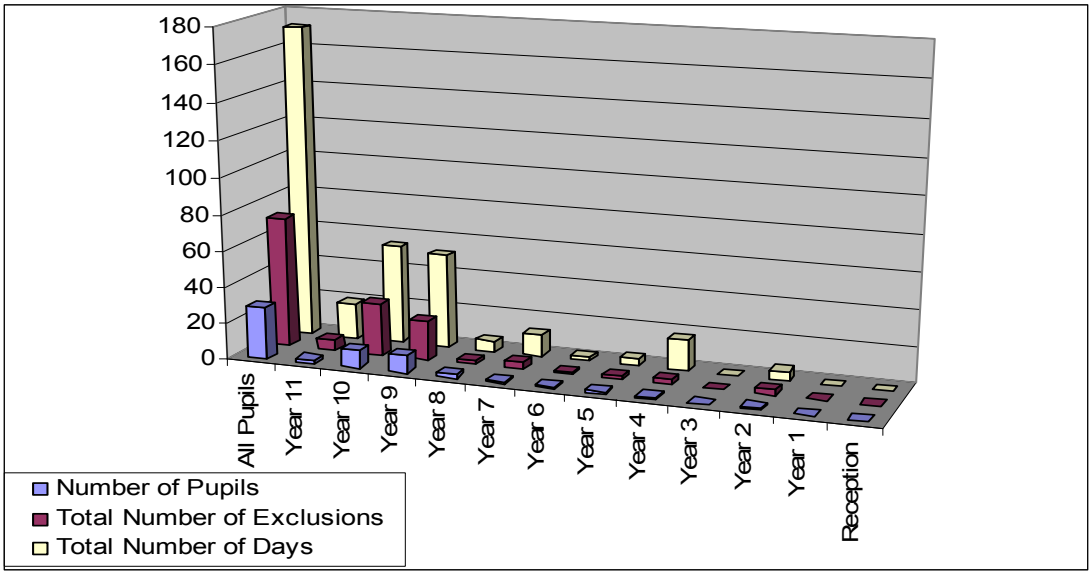
During academic year 2010/11, 29 pupils were excluded for a total of 72 exclusion episodes, accumulating to 172 days. This included 3 permanent exclusions for 2 pupils.

Table 5 - Exclusion of Statutory School Age LAC

Academic Year 2010/2011	Number of Pupils	Total Number of Exclusions	Total Number of Days
All Pupils	29.0	72.0	172.0
Year 11	2.0	6.0	19.5
Year 10	10.0	29.0	54.5
Year 9	10.0	22.0	52.0
Year 8	2.0	2.0	6.0
Year 7	1.0	4.0	12.0
Year 6	1.0	1.0	2.0
Year 5	1.0	2.0	4.0
Year 4	1.0	3.0	17.0
Year 3	0.0	0.0	0.0
Year 2	1.0	3.0	5.0
Year 1	0.0	0.0	0.0
Reception	0.0	0.0	0.0

Chart 9

Exclusion of Statutory School Age LAC



5.0 CONCLUSION

- Whilst the attainment of Hillingdon LAC continues to improve, the challenge remains to close the gap which exists between LAC and all pupils. This is against a backdrop of national attainment increasing at a faster rate than LAC attainment and Hillingdon Schools performing above the national average.
- LAC will continue to need priority access to assessments for SEN, appropriate services and additional resources to ensure that they are not further disadvantaged. This is against a backdrop of change, as more schools become academies and the commissioning of services.
- Placement stability and planned moves with education provision already identified and able to meet the child's needs will continue to play a significant role.
- A reduction in those children placed outside the borough, particularly at KS4, will enable them to access Hillingdon's education provisions. However, it should be noted that this year over one third of our Year 11s had a statement of Special Education Needs with 80% of these pupils being placed out of the borough, many in special schools, including Independent Schools and alternative provisions. There is therefore still a significant need for local resources to be developed which can meet the specific needs of these pupils.
- The current programme of carer recruitment and the focus of maintaining LAC within Hillingdon and bringing LAC back into the borough will have a significant impact on local education and health resources e.g CAMHs
- The development of the Multi-Dimensional Foster Care Treatment Programme Pilot, for children aged 6-11 years should lead to the reduction of placement breakdowns, changes in school places and this intensive programme of support and training should skill up the workforce for the future. Such changes will have a positive impact on the attainment and well-being of Hillingdon's LAC.
- Hillingdon Virtual School will continue to work to raise the attainment of LAC in line with our School Development Plan.

Education & Children's Services POC
Review Topics 2011/12

Contact Officers: Gill Brice
Telephone: 01895 250693

REASON FOR ITEM AND URGENCY

To enable the Committee to discuss options for a second review it wishes to undertake in the 2011/12 Council year.

OPTIONS OPEN TO THE COMMITTEE

Agree topics for a second review in 2011/12

INFORMATION

1. The Committee is responsible for undertaking the 'policy overview' role in relation to the services provided by the Education & Children's Services Group. The full range of services under the Committee's remit is outlined in the terms of reference attached as appendix.

2. Previous experience from both Hillingdon and other Councils indicates that the Committee can have the greatest impact by focusing on a work programme agreed at the start of the Council year. Similarly, focusing upon one or two items at each meeting can help Members engage with the major issues and encourage stakeholder engagement.

3. As in previous years, the Committee is recommended to use this first meeting of the year to set a work programme for the next 12 months and select one or two topics for major review.

4. In selecting topics, Members are reminded of the Committee's work in from 2006 to 2009, which included reviews of:

2006/7

Transition form Primary to Secondary School
Widening the Scope of the Education Service

2007/8

Extended Schools and Children's Centres
Meeting the Needs of Troubled Teenagers

2008/9

Development of Inclusion in Hillingdon Schools
14 to 19 Strategy
Develop a Short Breaks Provision

2009/10

Child Trafficking
Arrangements and future plans to support inclusive practice in Hillingdon Schools are effective.

2010/2011

14 – 19 Education and Training.

SUGGESTED SCRUTINY ACTIVITY

Members agree another topic for an in-depth review, using the selection criteria below suggested by the Audit Commission and their knowledge of residents' priorities.

Selection criteria recommended by the Audit Commission

(A) Possible Reasons for Scrutiny

Strong public interest
Government pressure
Included in the council plan or Hillingdon Improvement Programme
Inspection report recommendation (e.g. performance below target)

(B) Scope for Making an Impact

Area within Council's control/influence
High impact on residents
Expertise available on which to draw
Good practice available elsewhere

Terms of Reference

The Constitution defines the terms of reference for Policy Overview Committees as:

The Following Terms of Reference are Common to all Policy Overview Committees (referred to below as "The overview role"):

1. To conduct reviews of policy, services or aspects of service which have either been referred by Cabinet, relate to the Cabinet Forward Plan, or have been chosen by the Committee according to the agreed criteria for selecting such reviews;

2. To monitor the performance of the Council services within their remit (including the management of finances and risk);

3. To comment on the proposed annual service and budget plans for the Council services within their remit before final approval by Cabinet and Council;

4. To consider the Forward Plan and comment as appropriate to the decision maker on Key Decisions which relate to services within their remit (before they are taken by the Cabinet);

5. To review or scrutinise decisions made or actions taken by the Cabinet, a Cabinet Member, a Council Committee or an officer.

6. To make reports and recommendations to the Council, the Leader, the Cabinet, a Policy Overview Committee or any other Council Committee arising from the exercise of the preceding terms of reference.

This Committee performs the policy overview role outlined above in relation to:

1. All of the functions of the Council as an education authority under the Education Acts, School Standards and Framework Act 1998 and all other relevant legislation in force from time to time;

2. Pre-school and the Council's work with the Early Years Development and Childcare Partnership

3. The Youth Service and the Council's work with the Connexions Service and Partnership;

4. Social Care Services for Children, Young Persons, and Children with Special Needs.

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FORWARD PLAN 2011/2012

Contact officer: Gill Brice
Telephone: 01895 250693

REASON FOR ITEM

The Committee is required by its Terms of Reference to consider the Forward Plan and comment as appropriate to the decision-maker on key decisions which relate to services within its remit (before they are taken by Cabinet or Cabinet Member).

OPTIONS OPEN TO THE COMMITTEE

- To comment on items going to Cabinet or Cabinet Member for decision.
- Or to note the items and decide not to comment.

INFORMATION

1. The latest published Forward Plan is attached any additions to the current published Forward Plan will be provided at the meeting. The Committee may wish to consider the non standard items that fall within its remit.

SUGGESTED COMMITTEE ACTIVITY

To consider whether there are comments or suggestions that the Committee wishes to make.

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The Cabinet Forward Plan

Period of Plan: November 2011 to early 2012

Ref	Report Title	Advance information	Ward(s)	Report to Full Council	Cabinet Member(s) Responsible	Officer Contact	Consultation	Background Documents	NEW ITEM

SCH&H = Social Care, Health & Housing; **CS** = Central Services; **PEECS** = Planning, Environment, Education & Community Services

Ref	Report Title	Advance information	Ward(s)	Report to Full Council	Cabinet Member(s) Responsible	Officer Contact	Consultation	Background Documents	NEW ITEM
SCH&H = Social Care, Health & Housing; **CS** = Central Services; **PEECS** = Planning, Environment, Education & Community Services									
Cabinet Member Decisions - November 2011									
669	**Guru Nanak Sikh Primary School - statutory consultation on transfer of responsibility**	The Secretary of State recently approved proposals by Guru Nanak Sikh Academy to lower its age range to encompass the nursery and primary phases of education. This would create an all-through Academy catering for ages 3-19 from 1st September 2012. In order to facilitate this change, the Council has been advised to formally close the existing Guru Nanak Sikh Primary School as a local authority maintained school. The Guru Nanak Sikh Academy would then maintain the primary school buildings and provide the same number of nursery and primary school places from 1st September 2012. The Cabinet Member will therefore be asked to agree the start of statutory consultation procedures to this effect.The proposed closure is actually a transfer of responsibility from the Council to the academy trust (the Nanaksar Trust). There will be no change to the number of school places, and the recently built primary school will in future operate as the primary phase of Guru Nanak Academy.	Townfield specifically, but various wards inside and outside the Borough		Cllr David Simmonds	PEECS - Terry Brennan	Stakeholder groups prescribed by school organisation regulations.	Statutory school organisation regulations.	**NEW**
663	**Phase 3 Children's Centre Contract Variation Report**	The report to the Cabinet Member will seek approval, in line with current Procurement Standing Orders, for a contract variation.	N/A		Councillor David Simmonds / Cllr Scott Seaman-Digby	PEECS - Michael Kinsella	Corporate Procurement		
Cabinet - 24 November 2011									

Ref	Report Title	Advance information	Ward(s)	Report to Full Council	Cabinet Member(s) Responsible	Officer Contact	Consultation	Background Documents	NEW ITEM
SCH&H = Social Care, Health & Housing; **CS** = Central Services; **PEECS** = Planning, Environment, Education & Community Services									
699	**The Willows Special School, Stipularis Drive, Yeading**	This report to Cabinet will seek approval for the Council granting a 125 year lease to the school as a requirement of the conversion of the school to Academy Status.	Yeading		Cllr David Simmonds / Cllr Jonathan Bianco	PEECS - Michael Patterson			**NEW**
Cabinet - 15 December 2011									
647a	**The Council's Budget - Medium Term Financial Forecast 2012/13 - 2015/16**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2012/13 for consultation, along with indicative projections for the following three years.	All		Cllr Jonathan Bianco	CS- Paul Whaymand	Public consultation through the Policy Overview Committee process and statutory consultation with businesses & ratepayers		
Cabinet Member Decisions - December 2011									

Ref	Report Title	Advance information	Ward(s)	Report to Full Council	Cabinet Member(s) Responsible	Officer Contact	Consultation	Background Documents	NEW ITEM
SCH&H = Social Care, Health & Housing; **CS** = Central Services; **PEECS** = Planning, Environment, Education & Community Services									
686	**Cowley St. Laurence (Church of England) Primary School change of status from Voluntary Controlled to Voluntary Aided**	The governing body proposes to change the category of school from Voluntary Controlled to Voluntary Aided. The proposals will facilitate the development of the school buildings; improve the ethos of the school; preserve the links between the school and the church; and give greater autonomy over the maintenance of school buildings and school admissions. The Cabinet Member will be asked to approve the statutory proposals to change status from 1st January 2012.	Uxbridge South / Brunel		Cllr David Simmonds	PEECS - Terry Brennan	Statutory Consultation	DfE Guidance "Making Changes to a Maintained Mainstream School (Other than Expansion, Foundation, Discontinuance & Establishment Proposals)"	**NEW**
	Cabinet - 26 January 2012								
582b	**Music tuition in Hillingdon - Phase 2 of the Working Group's review**	Cabinet will receive a report on Phase 2 of the Working Group's in-depth review into music tuition, chaired by Councillor Judy Kelly. The Working Group will review possible alternative methods of delivering music tuition in Hillingdon and produce a second report to Cabinet with options / recommendations as to how good quality music tuition can be delivered on a cost effective, sustainable basis.	All		Cllr Ray Puddifoot / Cllr David Simmonds	Tricia Collis / Democratic Services	Working Group meetings, site visits and witness sessions	Working Group (Phase 1) report to Cabinet on 26 May 2011	

Ref	Report Title	Advance information	Ward(s)	Report to Full Council	Cabinet Member(s) Responsible	Officer Contact	Consultation	Background Documents	NEW ITEM
SCH&H = Social Care, Health & Housing; **CS** = Central Services; **PEECS** = Planning, Environment, Education & Community Services									
Cabinet - 16 February 2012									
647b	**The Council's Budget - Medium Term Financial Forecast 2012/13 - 2015/16**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the proposed General Fund reserve budget and capital programme for 2012/13, along with indicative projections for the following three years.	All	#######	Cllr Jonathan Bianco	CS- Paul Whaymand	Public consultation through the Policy Overview Committee process and statutory consultation with businesses & ratepayers		
516	**Schools Budget 2012/13**	To agree the Schools budget following consultation.	All		Cllr David Simmonds	CS - Amar Barot / Georgina Ayling	Schools Forum		

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WORK PROGRAMME 2011/2012

Contact Officer: Gill Brice
Telephone: 01895 250693

REASON FOR REPORT

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of each agenda.

OPTIONS OPEN TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and reviews.

INFORMATION

Meeting Dates and Rooms - ***Meetings start at 7pm unless indicated below***

Meetings	Room
8 June 2011	CR5
5 July 20111	CR5
7 September 2011	CR5
19 October 2011	CR5
23 November 2011	CR5
19 January 2012	CR5
9 February 2012	CR5
20 March 2012	CR5
24 April 2012	CR5

EDUCATION AND CHILDREN'S SERVICES POLICY OVERVIEW COMMITTEE

2011/12

WORK PROGRAMME

8th June 2011	School Admissions Update
	First Review – Agree topics for scoping reports.
	Cabinet Forward Plan
	Work Programme

5th July 2011	First Review – To receive Scoping Reports on the Review subjects agreed by the June Committee
	Quarterly Performance & Budget Report
	Cabinet Forward Plan
	Work Programme

7th September 2011	First Review – Elective Home Education (EHE) – Receive Amended Scoping Report
	Witness Session 1 - EHE
	Update on 2 Review Recommendations
	Cabinet Forward Plan
	Work Programme

19th October 2011	Witness Session 2 - EHE
	Update on a Previous Review Recommendations
	Cabinet Forward Plan
	Work Programme

23rd November 2011	Draft Annual Report of the Hillingdon Safeguarding Children Board
	Witness Session 3 - EHE
	Consider Topics for 2nd minor Review
	Quarterly Child Social Care Audit Update 2010/2011
	Update on Looked After Children
	Cabinet Forward Plan
	Work Programme

19h January 2012	Draft Budget for Consideration
	Final Report for Review
	Scoping Reports for Second Minor Review Topics
	Update on Funding for Youth Services previously provided by Connexions.
	Cabinet Forward Plan
	Work Programme

9th February 2012	Scoping reports for Minor Review
	Standards and Quality in Education
	Second Minor Review – Witness Session 1
	Cabinet Forward Plan
	Work Programme

20 March 2012	Quarterly Child Social Care Audit Update 2010/11
	Second Review – Witness Session 1
	Cabinet Forward Plan
	Work Programme

24th April 2012	Update on 2 Previous Review Recommendations
	Second Minor Review – Final Report
	Cabinet Forward Plan
	Work Programme

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