APPENDIX A

Hillingdon Local Safeguarding Children Board

Annual report

2011 - 12

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

APPENDIX A

INDEX

1. INTRODUCTION 3

2. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS 7

3. LEARNING FROM CASE REVIEWS AND AUDITS 22

4. WORKFORCE 28

5. HOW WE ARE DOING: effectiveness of local safeguarding 34

6. NATIONAL AND LOCAL CONTEXT: implications for safeguarding 46

7. WHAT WE NEED TO DO: priorities for LSCB 2012 onwards 48

8. CONCLUSIONS AND RECOMMENDATIONS TO THE CHILDREN'S TRUST 50

9. APPENDIX 1: LSCB membership 52

10. APPENDIX 2: Glossary 54

11. APPENDIX 3: LSCB Budget 56

APPENDIX A

1. INTRODUCTION

This report covers the work of the Local Safeguarding Children Board (LSCB) during 11-12. 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 characterised by a continuation in the increased number of children in need of protection coming to notice, alongside the financial constraints and organisational change noted in 2010-11. Clearly, more children experiencing, or at risk of harm, are being identified and helped. However, ensuring effective safeguarding against a back drop of dwindling resources and change becomes more and more challenging. During 2012 the Olympics will put additional strain on services across London, and we also have to respond to current imperatives, such as the recent emphasis on identifying and responding to child exploitation.

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

Hillingdon is the second largest of London's 32 boroughs. It has a population of approximately 266,100 at mid 2010 (269,011 by 2012) of which approximately a quarter are under 19. (8.7% 0-5) 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.

The birth rate has risen consecutively since 2006, with this increase being predominantly in the south of the Borough

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

During 2012 there will be some impact from the Olympics, with Police capacity likely to be particularly affected.

During 2011-12 3276 referrals were received by social care. This was a 17% increase from the previous year. There was an increase of 20% in the number of initial assessments carried out, a 69% increase in core assessments, and a 78% increase in the number of child protection enquiries. At 31st March 2012 there were 351 children with child protection plans, significantly more than at the same time last year (232) This increase has a huge impact across all agencies.

Lynda Crellin

Independent Chairman

June 2012

APPENDIX A

WHAT WE HAVE DONE

What we planned to do – our key priorities

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

Five priority areas of work were identified and these are detailed below with a summary of work completed against those priorities during 2011-12.

Priority 1 Improving infrastructure and functioning of LSCB

- Membership reviewed and reduced to ensure appropriate levels of representation
- Merged processes with SAPB. Both Boards meet on same day and discuss common agenda items during cross over time
- Quality assurance framework further developed and agreed
- Information for children and young people placed on Council website and system installed to obtain views from those placed on CP plans
- Safeguarding messages are now on information screens in children's centres
- Anti-Bullying steering group has merged with the E-safety sub group with shared terms of reference, to ensure more effective use of resources

Priority 2 Ensuring effective and improving operational practice

- Threshold criteria re-launched and awareness promoted though the developments of family support services
- Risk Panel set up to facilitate multi agency discussion of cases that are stuck and/or causing concern.
- Review instigated on two cases
- Safeguarding audit introduced and completed by schools. This is now part of the routine QA programme
- Took the initiative in raising concerns about CAMHS which will be followed up in 2012
- Schools safeguarding clusters piloted in the south of the Borough to improve communication between schools and social care

APPENDIX A

Priority 3 Improving outcomes for children affected by key risk areas – particularly domestic violence, adult mental health, substance misuse, and online bullying

- Continued good performance in respect of young people at risk of trafficking. Hillingdon participated in the review of National referral mechanism and was quoted in home Office Strategy document
- Signed up to London bid for European funding to support domestic violence services and prepared a bid for funding for therapeutic services for children
- Increased awareness of domestic violence issues among young people through training in schools and distribution of publicity material.
- All primary schools now have a cyber mentor and there are 5 in secondary schools. They offer guidance to students who contact them for advice.
- Information about e-safety distributed to all schools via a termly newsletter
- Care pathway developed and publicised for children abused or sexually assaulted

Priority 4 Ensuring a safe workforce

- New ISA guidance and Government guidance on allegations rolled out to all schools
- Guidance on recording staff safeguarding issues rolled out to all schools
- 130 days of multi agency training delivered, attended by 1324 staff from 18 agencies

Priority 5 Learning from Case reviews

- SCR published and action plan completed
- Completed the SCIE pilot case review and developed comprehensive action plan
- Continued to implement learning from unexpected child deaths – relevant issues communicated to DfE and local policies and procedures changed as appropriate

APPENDIX A

2. 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.

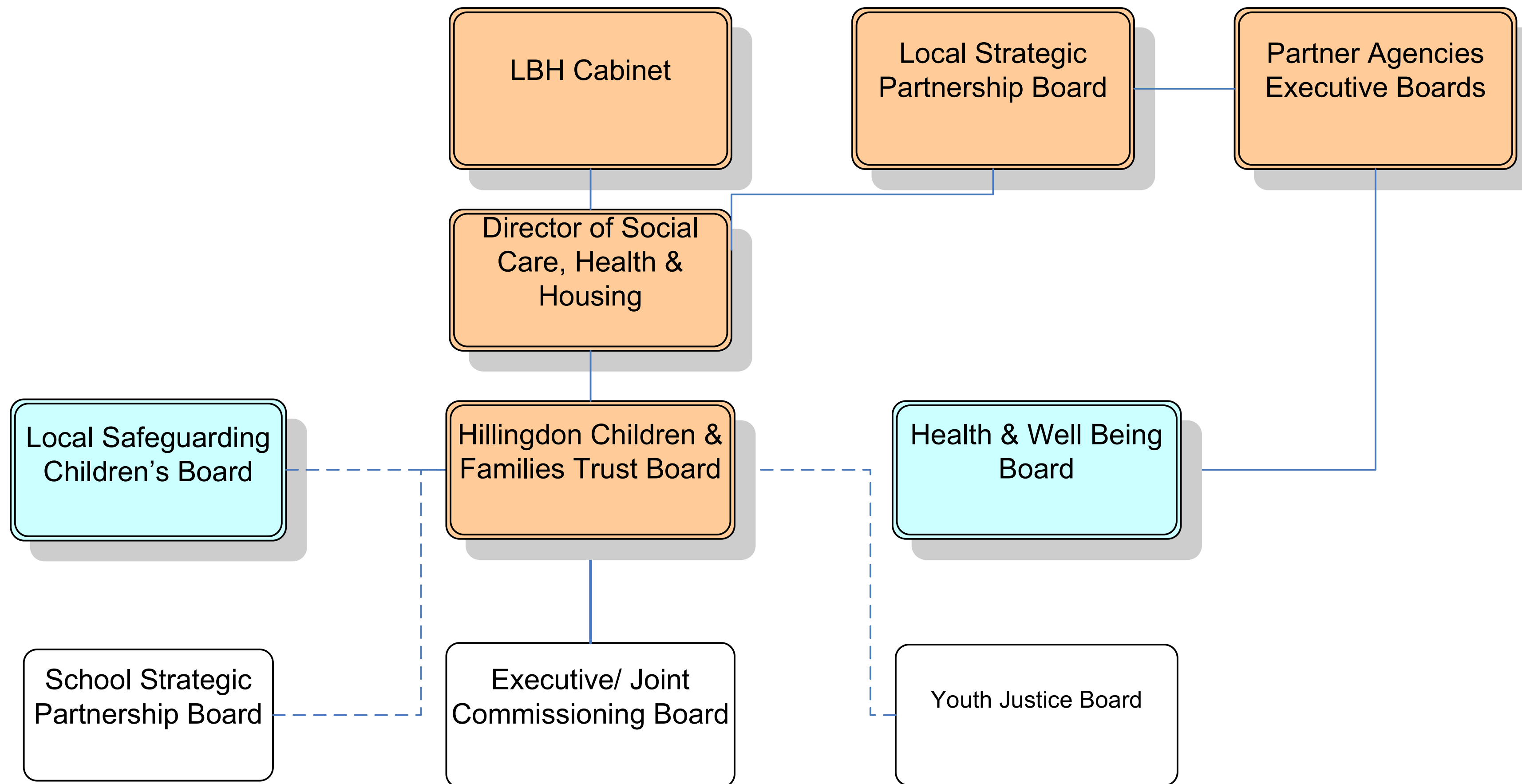
Sub group chairs and LSCB officers meet monthly with the chairman to undertake detailed planning for the Board and to monitor progress against the Business Plan and Partnership Improvement plan (PIP).

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

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

APPENDIX A



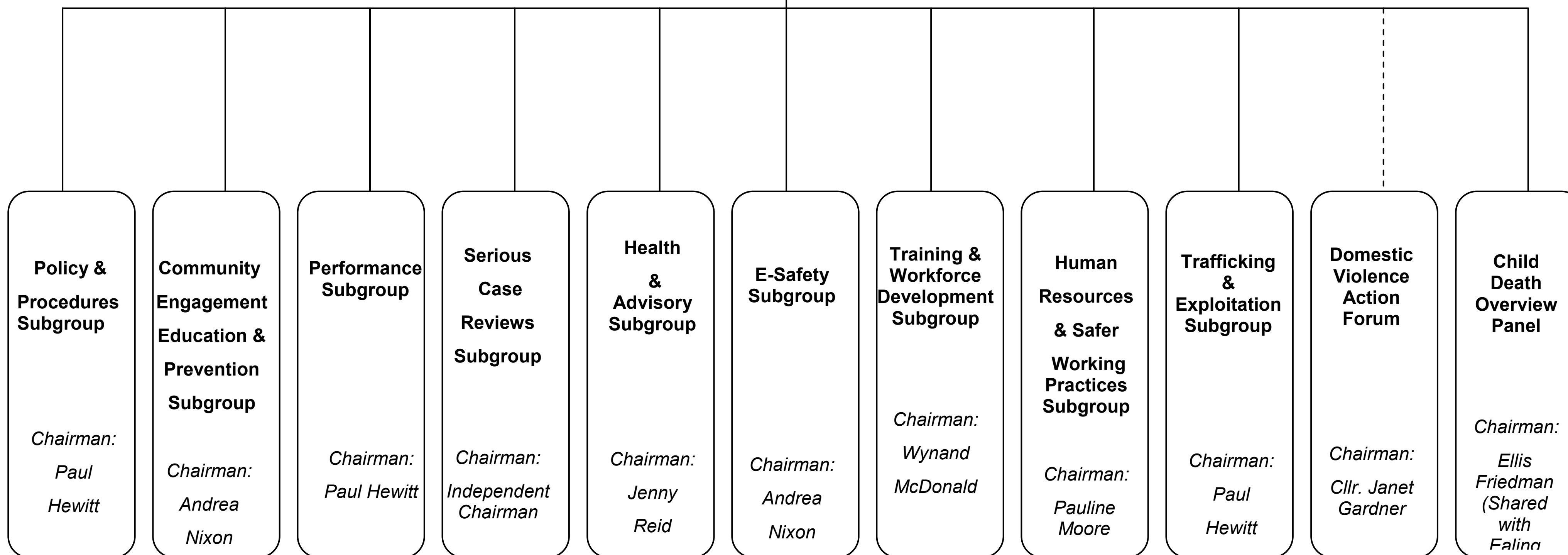
LSCB Governance

APPENDIX A

THE STRUCTURE OF HILLINGDON'S LOCAL SAFEGUARDING CHILDREN BOARD

Hillingdon LSCB

Independent Chairman: Lynda Crellin



APPENDIX A

Membership

The LSCB is a large, inclusive and generally well attended Board, supported by strong sub groups. Overall attendance during 2011-12 was 76%, an increase of 7% from last year. 100% attendees were CAIT and the voluntary sector, with Health and the Local Authority showing 88% and 78% respectively. Education and Police showed 75% attendance; Border & Immigration and Probation showed 50%. CAFCASS did not manage to send a representative, due to management changes. The Executive member acts as participant observer on the LSCB in order to ensure he is able effectively to discharge his political accountabilities. He and the Chief Executive attend on an occasional basis and receive papers. Membership was reviewed during the year to ensure the right level of senior representation across agencies. A list of members is attached at appendix 1.

An important gap is representation of general practitioners as providers of services, and the newly forming Clinical commissioning Group on the LSCB. A lead GP for safeguarding has attended the health sub group but appropriate representation will need to be addressed over the next period.

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 later in 2012. 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 Health and Housing (designated DCS) and by the Deputy Directors for Social Care and Education. Most of the statutory indicators for safeguarding rest with social care and these are monitored monthly and also shared with the Corporate Management Team, Chief Executive and Lead Members on a quarterly basis. The Lead Member and Chief Executive receive monthly updates on local safeguarding issues and attend regular safeguarding meetings with senior officers across children's social care education youth and early years services. The Children's Scrutiny Committee reviews key safeguarding areas – the most recent of these being children educated at home and social care audit report. Recommendations are incorporated as appropriate in the LSCB work plan. This report will be presented to Scrutiny Committee and Cabinet.

APPENDIX A

Social Care

Throughout 2011/2012 the Local Authority has kept safeguarding children as one of its key priorities, throughout the transformation processes being implemented within the Council. The staffing levels at the front line of Children's Social Care have been maintained with no cuts, and even increased by 4 posts. The greatest challenge has been to recruit and then retain qualified, experienced social workers and managers who can undertake complex child protection work with troubled families. This has remained a challenge throughout the year and has been a significant concern going into the new financial year of 2012-2013.

Internal Governance arrangements

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

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

Running alongside the performance scorecard has been a quality audits programme, which has also helped to strengthen safeguarding and highlight areas for improvement. The findings from these audits are reported to POC on a quarterly basis. This leadership and governance within the Council was commended during the Ofsted pilot inspection in November 2011.

Although education and early year's services are managed under a separate directorate within the Council, the Director of Children's Services has been part of the ongoing transformation programmes around preventative service and early intervention. This has culminated in the Hillingdon Family Service, which is intended to help alleviate the pressure on statutory services by having a more holistic approach to troubled families across agencies. The Council has provided a lead in relation to this initiative of preventative services and early intervention.

The Council's contribution to safeguarding in 2011-12

One of the key Council contributions to safeguarding improvement during 2011/12 has been the greater alignment between adults and children's services. This has enabled a more holistic approach in relation to issues such as domestic violence, parental mental illness and substance abuse. The strengthened relationships between the Local Safeguarding Children Board and the Safeguarding Adults Partnership Board have been strongly promoted within the Council, as well as by partner agencies.

APPENDIX A

Actions planned for 2012-13

Further initiatives in safeguarding children and preventative and early year's services are being planned for 2012/13. Some of the key developments will be as follows:

- The construction of a Multi Agency Safeguarding Hub (MASH) in autumn 2012.
- The establishment of a Preventative Hub which builds on the work already incorporated into the prototype modelled by the Hillingdon Family Service and Triage Team.
- Strengthening of the quality audits programme in the Council by supporting the role of the newly appointed Quality Audits Manager.
- Preparedness for future Ofsted inspections in relation to child protection services, through implementation of a multi agency action plan, under the leadership of the Council.
- Strengthen arrangements for reviewing the quality of child protection plans, and child in need plans by appointing an additional Independent Reviewing Officer to build capacity for reviewing child in need plans, as well as child protection plans.
- Extended role for professional social work under the leadership of the designated principal child and family social worker. (Second annual conference for social workers in autumn 2012).

Youth Offending Service

Following the publication of an HMIP report (Who's Looking After the Children) which summarised the findings of a thematic inspection of the services for young people arrested and detained by the police, Hillingdon YOS and police partners have reviewed the key findings and recommendations of the report against local practice. A joint improvement plan has been developed focusing on

- Improved information gathering and sharing
- A revision of focus from the process to the safeguarding issues pertaining to arrest and detention of young people
- A review of procedures and associated training for staff

The YOS Management Board is currently reviewing the findings of the third review of healthcare in the community for young people who offend against local practice and it is likely that some activities will arise from that in 12/13.

The Legal Aid and Punishment of Offenders Act 2012 Sentencing Act received Royal Assent in May 2012. It introduces a number of key changes with respect to the remand of youths;

- A new remand order will replace existing arrangements and will apply to 12-17 year olds. There will be no differences in treatment based on age and gender as per the current system

- All young people subject to a new remand order for youth will become looked after by the local authority. A such these children young people will fall within the provisions of the Care, Planning and Review Regulations and Guidance
- Local authorities will assume the costs of all secure remands.

The implications of these developments are currently being reviewed by the YOS Partnership prior to the issuing of the commencement order. Whilst increasing the LAC population and the changed funding arrangements presents some challenges there is also the opportunity to use the devolved funding to develop some alternative placements to custodial establishments particularly for our more vulnerable young people.

Education and Early years

The year 2011/12 has continued to indicate significant change for Education Services and Schools, both nationally and in Hillingdon. Almost all secondary schools (except 2) in Hillingdon have now become Academies and operate as independent maintained schools. Currently there are no Primary Schools that have converted to Academy status. However a group are now formally considering this working with their Governing Bodies. 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.

Education, early years and youth services have been managed within the PEECS Directorate since 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. This work is linked to the development of the Hillingdon Families Service and Family Centres.

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 worked with schools on bullying –an important LSCB issue.

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. There is one school in an OFSTED category all other schools being at least 'satisfactory'/

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 have been under review given changes in national policy in relation to the provision of careers information, advice and guidance for young people, this provision will continue in Hillingdon for vulnerable children.

Voluntary Sector

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

Unlike the other agencies represented at the LSCB, the diversity and independence of the sector makes it difficult to generalise about arrangements for safeguarding in the sector. There are as many different arrangements as there are organisations.

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

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

This support is provided by HAVS.

Each individual organisation is responsible for their own contribution to improving safeguarding. Common actions by many over the last year include updating policies and procedures, developing how they recruit safely and reviewing cases. In the coming year, organisations plan to continue their processes of training and retraining staff, and updating policies and various procedures. HAVS has undertaken to step up advertising that the services

mentioned in the previous paragraph are available for use by any organisation requiring them, and to review all resources used to support the voluntary sector.

Health Agencies

All the main health agencies are represented on the LSCB, including the joint Director of Public Health (DPH) who is the executive safeguarding lead, the designated doctor and designated nurse. The Designated Nurse is currently based within the Public Health Department and, alongside the Designated Doctor, has the main responsibility for overseeing safeguarding practice in each health agency. The designated professionals report directly to the DPH.

Each of the main Provider organisations has its own safeguarding steering group and these in turn feed into the NHS Hillingdon Safeguarding Committee which is chaired by the DPH. Some of the quality assurance work and monitoring of key actions rest with the health sub group of the LSCB, however, the overarching statutory duty (including quality assurance) to ensure that safeguarding and promoting the welfare of children is discharged effectively, rests with NHS Hillingdon and the successor NHS commissioning organisation.

The organisation takes this responsibility seriously and will ensure that safeguarding children remains a priority throughout and after the current NHS organisational changes.

Central and North West London Health (CNWL)

CNWL Governance Arrangements

CNWL operates across a large number of boroughs both inside and outside the London area providing a large range of services including community care, mental health and specialist services such as addictions, and prison health. A senior representative of the organisation attends each of the local children's safeguarding boards served by the organisation. At Trust Board level, the director lead is the Executive Director of Operations & Partnerships who also chairs the Trust's quarterly Safeguarding Committee. The Committee receives information about the boroughs that the Trust serves, assesses effectiveness of safeguarding arrangements in operation across the organisation, develops and oversees the annual safeguarding priorities across the Trust and reviews training provision and attendance.

The Safeguarding Committee provides a written report each quarter to the Trust Board. In addition, an Annual Report covering all parts of the Trust is submitted; the 2011/12 report was considered at the September meeting. Annual training is also provided to all Executive and Non-Executive Board members; most recently during September 2012.

Mental Health & Allied Health Specialities

CNWL Safeguarding Children Contribution

Establishing shared supervision arrangements: Children's Social Care, Addictions and Mental Health Services have agreed times when cases can be presented to each other for support and challenge.

APPENDIX A

Risk Assessment Procedures: CNWL revised our risk assessment process and recording and amplified the part on assessing risks in relation to safeguarding children. This included developing guides for all staff on safeguarding children and domestic violence. It may be helpful to explain that this includes routine questioning of all adult clients and whether they have experienced any domestic violence or a history of abuse.

Section 11 Audit: The Trust completed a Section 11 Audit for another Borough and this was shared with the Designated Nurses in February 2012. An evidence file documenting the supporting evidence of compliance is also available.

Safeguarding Children Helpline: The Safeguarding Children Helpline in use across the Trust was short-listed for a Safeguarding Children Award at the London Council and C4EO, and was highly commended for its innovative and cost effective practice.

Reviewing CAMHS Role: Commissioners have been working with CAMHS to review the service and there are concerns about the level of funding for the service, given the population size and need: there remain concerns around whether there is enough capacity to meet all local needs. Internally, CNWL have commissioned the Royal College of Psychiatrists to undertake a review to ensure that CAMHS are maximising the effectiveness of the limited resource.

CAMHS plan for 2012-13 following sec 11 audit

- Ensuring that Children and Young people are listened to
- Ensuring that Statement of agencies responsibilities towards children and safeguarding is available to all staff in the organisation
- Ensuring that Service development takes account of the need to safeguard and promote welfare and is informed where appropriate by the views of children and families
- Ensuring that staff who work directly with children are trained and briefed on when to use CAF and the lead professional in the team around the child to intervene early and obtain multi-agency additional support for children in need, including children at risk

Hillingdon Community Health, (HCH)

On the 1st February 2011 HCH, (formally part of Hillingdon PCT) merged with CNWL and adopted its overall safeguarding children's governance arrangements described above. In addition, the Community Services Managing Director is the current vice chair of Hillingdon's Local Safeguarding Children Board (LSCB). She also chairs the local HCH Safeguarding Group whose membership includes the community named nurses, named doctor and Hillingdon designated doctor.

The HCH Safeguarding Group provides a written report to the quarterly Trust Safeguarding Committee. This report summarises all the key issues in relation to safeguarding across HCH including the audit programme, progress in

delivery of the annual work plan, any identified risks and measures being taken to mitigate these.

There are professional links between all the named nurses across the Trust.

The local HCH Annual report was tabled at the CNWL quarterly Safeguarding Committee in July.

Contribution to safeguarding in 2011-12

- Local HCH guidelines reviewed and updated
- Well over 90% uptake at all levels of child protection training
- Named nurses completed NHS London leadership course
- Liaison health visitor developed electronic transfer of liaison referrals from A&E
- Strong commitment and involvement in child protection conferences and core groups –attendance well over 90%

Plans for 2012-13

- Merge HCH and CNWL safeguarding policies
- Develop 'before and after' outcome measures for families in child protection process (nil response to 2011 survey)
- Undertake supervision audit following introduction of new standards during 2011/12

Hillingdon Hospitals NHS Foundation Trust

Safeguarding children arrangements at the hospitals have continued to strengthen during 2011/12. The Executive Director for safeguarding, who sits on the hospital trust board oversees the annual work and audit programmes for safeguarding children and progress against these is now reported to the Trust's Safeguarding Committee, which is a merger of the Adult and Children's Steering Groups, and reports to the Clinical Quality and Standards Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2011. 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 improving the arrangements in the Accident and Emergency department with regard to nursing leadership and management of the paediatric area, supporting the development of the safeguarding midwife role and post-holders and introducing a supervision of practice protocol and supervision training for key staff. It has been agreed that domestic violence awareness needs to be raised across the organisation and as a result training has been organised and is to be delivered by HESTIA. Information provided to staff has been revised and is available via the Trust staff intranet. A review of safeguarding children training that is delivered has taken place to improve compliance with refresher training and additional sessions at all levels of training have been

made available to staff. Alternative modes, such as e-learning, have also been provided.

Key challenges moving forward in 2012/13 include:

- The achievement of >80% compliance with safeguarding children refresher training, particularly in light of revised intercollegiate guidance and the need for more staff to undertake further training.
- Ensuring high quality safeguarding practice amidst financial savings across all partner agencies, embracing the Department of Health's QIPP (Quality, Innovation, Prevention and Productivity) work-stream with regard to doings things differently to ensure the quality of care is maintained, despite cost improvement programmes.

An annual work programme has been developed to ensure priorities for 2012/13 are closely monitored and required actions progressed. The Trust is keen to work with partner agencies to ensure that information on patient outcomes in relation to safeguarding is captured to support further improvement work.

Metropolitan Police

Child Abuse investigation team (CAIT)

- The MPS has continued to deliver a commitment to providing regular training on safeguarding, child protection and effective leadership for managers and practitioners across frontline services. The MPS provision of Multi Agency Critical Incident Exercise (MACIE) training for each London borough has completed the delivery of training to all 32 Boroughs. Hillingdon borough has participated in this training.
- The Child Abuse Investigation Command, in partnership with the Leadership Academy has also developed a one day version of the MACIE training programme specifically for those at practitioner level. This has been rolled out and Hillingdon Borough has participated in this exercise.
- Following an extensive consultation exercise and pilot, new extended hours were introduced across the Command on 9th January 2012. The Child Abuse Investigation Command now operates cover between 8 am and 6 am. The new on call arrangements between 10 pm and 6 am operates on a Regional geographic basis offering additional support to Borough Policing thus maximising effectiveness in safeguarding children in the capitol.
- Over the last 12 months, SCD5 has enhanced the Child Risk Assessment Matrix (CRAM) across London to better inform decision-making. This process makes a qualitative assessment of all relevant factors relating to a child and allows appropriate and informed decision-making, and is now more comprehensively recorded on the police crime reporting data base.

APPENDIX A

- Responsibility for ensuring compliance and pan London governance of CAITs sits with the SCD5 Continuous Improvement Team (CIT). The CIT includes quality assurance, training and partnership. A rolling CAIT quality assurance inspection programme has been developed and implemented over the past 12 months. The inspections focus on comparative analysis in the six areas identified as critical to the success of the CRAM and effective joint working and are reported through a bi-monthly Detective Inspectors' meeting chaired by the OCU Commander. The six key thematic areas of the CRAM are; risk factors; risk assessment; supervision; records; communication. Hillingdon CAIT will next be inspected in Spring 2012.
- A new initiative has been developed by SCD5 working more closely with the Safer Neighbourhood Teams (SNT). Hillingdon CAIT now share information with the SNT about children on plans, which enables them to be more informed, and be an additional pair of eyes and ears on the ground in the monitoring and safeguarding of children in Ealing Borough.
- The Command has reviewed the Specialist Child Abuse Investigators Development Programme (SCAIDP) in line with the new learning descriptors produced by the NPIA. This enhanced National training is offered to new entrants to ensure that best practice is at the core of business.

Project Topaz has three strands that are designed to deliver benefits and more effective safeguarding and outcomes to children on Child Protection Plans. There are three strands;

- Project Pan-Pan. This is the way that CAITs involve and inform Safer Neighbourhood Teams of vulnerable children in their areas, and is up and running in all three Boroughs.
- New victim of allegations of abuse/crime. All children in London subject to a CP Plan are now monitored on a daily basis for early identification of new allegations of abuse. Police recognise the dangers of repeat victimisation and have introduced an immediate escalation process involving managers and supervisors to ensure that appropriate review and challenge is in place to safeguard the child.
- Effective Child Protection Plans. We have undertaken some review and analysis of all CPPs in London. We have engaged with the London Safeguarding Board Child Protection Advisors and some partner CSC managers to look at the way CPPs are currently being used and identify areas for improvement so that these plans can be much more effective.

This project will focus upon high risk child protection cases and the management of these with the emphasis being on building best practice in the recognition of risk at the earliest stage and assisting the partnership in delivering effective interventions to safeguard children.

APPENDIX A

Community Police

The Public Protection Desk [PPD], based in West Drayton, was under resourced for part of the year due to evolving factors. One officer retired and was not replaced immediately; a second was planning maternity leave; so could not take on long term project work. This was in the context of increased demand, in terms of children coming to notice of the Borough Police.

Despite these constraints, the PPD team did maintain a strong input and participation in the operational sub-groups of the LSCB; including the children missing education group, the children missing from care group and the safeguarding managers' meetings.

This enabled key safeguarding issues not dealt with by the Child Abuse Investigation Team [CAIT] to be addressed in the borough with colleagues from health, children's social care and education. One of the key issues to be addressed was young people being potentially exposed to gangs or groups within the Borough. The police community safety offices [PCSOs] visited almost all the schools in the borough to raise awareness about the potential for young people to be caught up in gangs; and also provided some practical strategies to children and young people of how to counter this if it happened to them.

The multi-agency risk assessment conference [MARAC] meeting has been growing in strength over the last year, and not only supports high risk victims of Domestic Violence, but also their children as they are collaterally and occasionally directly put at risk. The Independent Domestic Violence Advocacy [IDVA] team has worked very closely with the police staff in the community teams to ensure that there is an appropriate response for children whenever crises occur in relation to domestic violence. The IDVA statistics were presented to the LSCB main board meeting in November 2011, and showed an increased number of children being caught in domestic abuse situations; but at the same time being identified and safeguarded by the joint working of the community safety officers based in the West Drayton team and children's social care, and via all agencies at MARAC.

Similarly, the Multi-agency public Protection Arrangements [MAPPA] chaired by Borough Police has also grown in strength, with good multi-agency attendance being noted .There has been no significant increase in public disclosures of registered sex offenders despite the implementation of "Sarah's Law" which allowed for such disclosures to be made where vulnerable children may be at risk. Although not directly designed to protect children, MAPPPA does inevitably make a difference to the protection of children. We have received plentiful anecdotal evidence to this effect, from professionals across the children's workforce, and from new partners with children in relationships with registered sex offenders who have been unaware of the potential risk presented to their children.

The proposed new Ofsted multi-agency inspection framework could include observations of both MARAC and MAPPPA. With this in mind the Borough Police do feel well-positioned to make a significant contribution to the well-being and protection of children in the locality.

APPENDIX A

The borough commander met with partner agencies about the establishment of a multi-agency safeguarding hub [MASH], and has committed to making this come to fruition in the forthcoming year, making use of the learning from other MASH pilots across the country. The MASH will no doubt help to co-ordinate early responses to troubled families; and will also help to organize the filtering of Merlins and PACs, as this remains an area for improvement and development.

The Borough Police teams have welcomed the greater links between the safeguarding adults partnership board [SAPB] and the Local safeguarding children board; and will retain a strong commitment to the work of both boards in safeguarding vulnerable adults and vulnerable children. Hopefully this collaborative and integrated approach to safeguarding; can be translated into the MASH in the forthcoming year to build on the sound progress made to date.

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 the SCIE pilot case review which incurred considerable costs for independent reviewers. [See Appendix 3].

It should also be noted that this is the final year that the UK border agency are able to make a specific contribution to the pooled budget of the LSCB (£5,000.00). The border agency financial contribution for ensuing years is consolidated into the overall grant made to Hillingdon Council, as a contribution towards safeguarding the needs of vulnerable as a Gateway Authority.

Part way through the year, a one-off government grant of £29k was also made to the LSCB to help assist with the implementation of the Munro recommendations. This money will be used to support a range of multi-agency case audits which will help to promote local learning across the safeguarding community. This program of multi-agency case audits with carry over into the next year 2012-2013 as part of the Business priorities of the LSCB.

APPENDIX A

3. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Reviews (SCRs)

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

However, a report was published from a SCR in another authority relating to sexual abuse in a primary school. Many of the messages from this reflected the learning from our SCR that took place last year. The report and its conclusions were passed on to all schools in Hillingdon as a refresher to the action plan developed in Hillingdon in 2011.

A further case in Rochdale has had considerable national resonance. This case raised the issue of the particular vulnerabilities of young people (young women in this case) looked after in respect of risks of sexual exploitation particularly as a result of going missing. The Government responded swiftly and a parliamentary Select Committee investigation took place with a report and recommendations published in summer 2012.

Locally, a review will be carried out by the Council Scrutiny committee.

Hillingdon's multi agency operational group which identifies children missing from home or care will be the mechanism for continuing to develop the effectiveness of this area of work.

Other case reviews - the SCIE pilot

Towards the end of 2010-11 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 completed in autumn 2011. The findings were discussed at a joint meeting of the SCR sub committee and the case review group. The main findings indicated a failure to recognise and manage chronic neglect, along with a failure of escalation systems to respond to agencies concerns. These are familiar themes that have been reflected in other cases both locally and nationally. The LSCB and the Children's Trust have developed a response plan which includes a strengthening of the LSCB quality assurance role and the development of a risk panel to review stuck and worrying cases. The learning has also influenced the development of preventative services.

Other cases –management review

A further management review was carried out in spring 2012. The review involved a family with children where a parent had a mental illness, and was a joint review by Hillingdon Council and CNWL. The following key learning points were identified:

The need to refresh and reactivate the existing inter-agency protocol between Mental Heath services and Children & Families Service, particularly the need

for professionals to meet and develop a fully multi agency assessment of need, and an understanding of language used in case planning across the two agencies

The need to ensure that staff in both services are able to take account of the impact of actions on children and adults in a family.

The need to improve management oversight in order to ensure that the two actions above could be implemented

Relevant actions for each agency are now included in the Partnership Improvement Plan.

Case Audits

Two cases were discussed at the SCR sub committee. Although they did not meet the criteria for SCR it was agreed that a management review would be undertaken on both cases, involving mainly vulnerable adolescents. An independent reviewer, James Blewett was commissioned to do this work. James has undertaken several reviews in Hillingdon including the recent review carried out as part the SCIE Learning Together project. These additional multi-agency reviews concluded that

- There are many learning points from both cases that are closely related and linked to those that emerged in the previous SCIE Review which involved work with a vulnerable adolescent. That is that it is all too easy when working with older adolescents to minimise the safeguarding issues and focus on the behavioural issues. In common with messages from national research it is also easy *not* to recognise the degree of harm these young people can experience because of assumptions about safety based on them being older.
- Many complex inter-agency issues arise when working with vulnerable adolescents. It is not so much that they are "under the radar" of agencies. Indeed they are often well known to services but ensuring that there is a strong coordinated response can be difficult
- There was some evidence of good practice and of professionals being very committed to working with the adolescents concerned, particularly with regard to the Police, CAMHS and Hillingdon Tuition Centre. Indeed Ofsted commended some of this work in their survey of *children on the edge of care,* undertaken in October 2011.
- Like the SCIE case, issues about the quality and timeliness of the assessments by children social care arose; particularly when concerns about the child's welfare have been raised on an on-going basis. Timeliness is not just to be seen in terms of chronological timescales and targets for key performance indicators, but more importantly optimum timeliness for the child/young person in need of protection.
- A strategy has been put in place by managers in children's social care to address these concerns and partner agencies [E.G Risk Management Panel—see below]. However, the Board will want to ensure that this crucial element of the child protection system is

continuing to work as effectively as it can; especially in relation to vulnerable adolescents.

Risk Management Panel

In November 2011, a multi-agency Risk Management Panel was established to address the safeguarding issues related to high risk cases identified by partner agencies. The Risk Management Panel has its own terms of reference and includes a focus on learning lessons for practice from the issues identified at the Panel meetings. All partner agencies are represented at the Risk Management Panel, including the Child Abuse Investigation Team, Health Provider Services and a Council legal representative. Where needed, Adult Mental Health Services for substance misuse and parental mental illness are invited to the Panel on a case specific basis. Schools are also able to bring forward high risk cases via the CP advisor for schools, if they have become stuck.

In total, there have been three Risk Management Panels chaired by the Service Manager for the Family Support Services within Children's Social Care. Meetings have been scheduled on a bi-monthly basis for the duration of the next year. (2012-2013).

Up to 1st April 2012, the Risk Management Panel had examined eighteen cases in total.

The feedback from the partner agencies about the Risk Management Panel is that it has been very effective in balancing risk and sharing it between the professional network, whilst focusing on creative ways of ameliorating the risk to vulnerable children. Some of the key issues and learning in the eighteen cases are as follows;

Low levels of repeated domestic violence that have resulted in neglect and emotional harm to children exposed to it.

The lack of a local intervention programme for perpetrators of domestic violence where there is no conviction or ongoing court action.

Creative use of civil court interventions, such as an Exclusion Order linked to an Interim Care Order, to enforce the eviction of perpetrators of domestic violence.

The agency chronologies produced at the Risk Management Panel are showing some families with cyclical inter-generational patterns of abuse; particularly neglect. Allied to this has been an observable under use of children's centres, where parenting programmes could be helpful in breaking the cycle of neglect.

The lack of a holistic approach to assessments of need, where parents have parental mental illness at a low level, such as depression or mild learning disability.

Some of the issues and learning from these cases are now being picked up in the Children's Pathway Programme where it is known that better use of universal and targeted services in children's centres is essential to prevent the need for statutory intervention. Also a more co-ordinated interagency

approach to domestic violence is now being viewed as a priority in the Children's Pathway Program.

The Risk Management Panel will continue to meet and evolve in the next year, and will focus on engaging core agencies on high risk cases, without taking the cases themselves out of the recognised pathway for addressing care issues in a collaborative manner, through the child protection system. Further analysis of the cases and themes will be used for promoting the learning and development of professionals in the workforce, working with vulnerable children in Hillingdon, as well as ongoing service development.

Audit of CP cases

In early 2012, a case sample of 50 children on CP plans [CPP] was audited via the safeguarding children and quality assurance service, focusing on children who had become subject to a CP plan for a second or subsequent time.

- Of the 50 children on their second CPP, thirty three percent of these children are aged 5 and under, a further 42% are aged between 5 and 12 and 25% are aged 12 and over. This is significant in that, more than 75% of children are under the age of 12 and have been subject to 2 periods of Child Protection plans and 25% of children become subject to CPP, the second time as teenagers.
- Ninety percent of children appear to become subject to CPP for similar issues the second time.
- Domestic Violence and the associated neglect / emotional harm is the main (48%) reason for children becoming subject to a second period of CPP.
- A further 30% of children become subject to CPP a second time due to parental substance misuse (30%) and the associated neglect.
- Parental mental health and sexual abuse appears to feature as reasons for CPP in small proportion of children's lives (22%)
- Sixty five percent of children subject to a second CPP have been known to the LA for more than 5 years.
- Thirty six percent of children have become subject to a second CPP within the last two years.
- Twenty percent of children subject to their second CPP were on their initial plan for more than 12 months.
- Eighty percent of these children became subject to their second CPP after their initial period being less than 12 months.

These findings reflect the anecdotal evidence about the prevalence of domestic abuse and neglect as intractable issues in some families which will need to be covered within the redesign of the children's pathway in Hillingdon which is scheduled for the autumn of 2012.

APPENDIX A

Audit of social care files

Also, in early 2012 the Quality and Assurance Unit carried out an audit of social care and Youth Offending Service files to assess the quality of the response following the Ofsted pilot and YOS inspections. Although some improvements were identified, such as some better quality chronologies, and children being seen more often, the impact of the continued increase in workload had resulted in some quality standards being compromised, with improvements needed in several areas, e.g. management oversight, and improved assessment quality across all levels of need from CAFs to core assessments.

By the end of the year, many initiatives were in place and planned as a response to this:

- Qualified social worker response to all potential risk cases at point of referral (confirmed by spot audit April 2012)
- System in place to track supervision and ensure feedback to referrers
- Enhanced support to IT recording systems
- Establishment of a multi agency risk panel to discuss cases causing concern
- Programmes of support and training in reflective supervision provided across agencies –initial feedback positive.
- Appointment of dedicated Audits manager to work across Children's' services and LSCB

In addition it is planned to introduce a Multi Agency safeguarding Hub (MASH) in autumn 2012/early 2013 to promote effective information sharing for children and adults.

Child Death Overview Panel (CDOP)

The joint Hillingdon/Ealing CDOP has continued to function effectively through the year.

There was a significant decrease in child deaths although the figures are too small to assess whether this is a blip or part of a downward trend.

Rapid response meetings took place in respect of all unexpected deaths and all of those generated immediate actions for agencies

31 Hillingdon child deaths were reviewed during the year.

There have been three cases in the year where the panel feels they have contributed to positive change; one involved a child jumping out of a window which lead to safety catches on windows being improved; one case involved a child on a school trip becoming trapped between the seats on a coach and processes and procedures are now being looked at; one case involved the emergency services being unable to reach a child, due to a barrier across the road being locked shut. Remedial actions have been taken and wider reviews are being considered across the Borough.

CDOP have continued to deliver local publicity to raise awareness of safety issues – e.g. safe sleeping for babies, window security in hot weather.

APPENDIX A

These issues continue to be dealt with on a local basis and the CDOP chairs continue to press for wider collation of trends and safety messages in order to ensure more effective learning from these reviews.

The funding arrangements for supporting CDOP changed during the course of the year, as the coalition government withdrew funding streams through area based grants [ABG]. The CDOP is now jointly funded by Hillingdon and Ealing Council, each making a contribution of £45k with a total annual budget of £90k. This budget pays for staffing and running costs to enable the CDOP manager and rapid response administrator, both based at the Hillingdon Hospital, to carry out the required functions for responding to unexpected child deaths. There is no longer surplus funding within this budget to pay for extensive public health awareness raising or campaigns. The CDOP panel has produced its own annual report which is available on the LSCB website.

http://www.hillingdon.gov.uk/index.jsp?articleid=16449

APPENDIX A

4. WORKFORCE

Evaluation of single and multi agency training

In 2011/12 the training sub-group delivered 16 different training courses in line with the LSCB agreed priorities; more diverse than training offered in 2010/11 but not as comprehensive as training offered in 2009/10. The table below provides an overview of course bookings:

	2009/10	2010/11	2011/12
Annual conference	190	196	161
e-learning	817	1511	1962
Training	2148	1081	1181
Total	3155	2947	3304

E-learning

Training hard to reach members of the workforce (e.g. frontline teachers, foster carers and the voluntary sector) remain a challenge. In 2010 the board agreed the introduction of an e-learning module to deliver level 1 (Introduction/ basic safeguarding training). 2011/12 has seen a sharp increase (29.8%) in course registrations and the highest number of passes since introduction of the course in 2010.

This learning method proved successful in reaching hard to reach staff and it is also cost effective. In the past, learners on more advanced courses often had an insufficient understanding of basic child protection principles which caused frustration and delays for learners who felt either overwhelmed with complex information or frustrated with facilitators reviewing information with which they were already well acquainted. This problem has now largely been eliminated which is a tremendous time saving and quality improvement at all training levels.

Domestic violence, parental mental health and core groups

The LSCB training priorities in 2011/12 were to focus on domestic violence, parental mental health and strengthening the quality of core groups and child protection plans. The training sub-group commissioned 2 one-day courses (40 places) on *Mental Health and Parenting Capacity* and in partnership with the IDVA service delivered 7 one-day courses (140 places) on *Domestic Violence and the Impact on Children and Young People*.

APPENDIX A

Priority area	Places offered	Booked	Cancelled	Attended
Mental health	20*	13 (65%)	3 (23.1%)	7 (53.8%)
Domestic violence	140	115 (82.14)	23 (16.4%)	82 (58.6%)
Core Groups	120	131(109.2%)	20 (15.3%)	100 (76.3%)
Total	280	**259 (92.5%)**	**46 (17.8%)**	**189 (72.9%)**

A wide variety of agencies booked places on courses but regrettably many participants (15.3 - 23.1%) cancelled or simply did not arrive on the day (8.3% - 23.1%). Even the courses for Core Group training that were 10% over-subscribed only trained 76% of booked on learners. In the case of mental health and parenting capacity one course had to be deleted because of a lack of interest and even then only seven people arrived for the presented course, a waste of 65% of the available numbers.

Anecdotally, the reasons given for cancellation are work pressures but the training sub-group will need to investigate this in more detail.

Statutory training

Working Together to Safeguard Children and *Working Together Refresher* training formed the bulk of statutory multi-agency training of the LSCB. As in previous years demand remained high, with more places offered than before (400 and 80), both courses were over-booked by 12-13%.

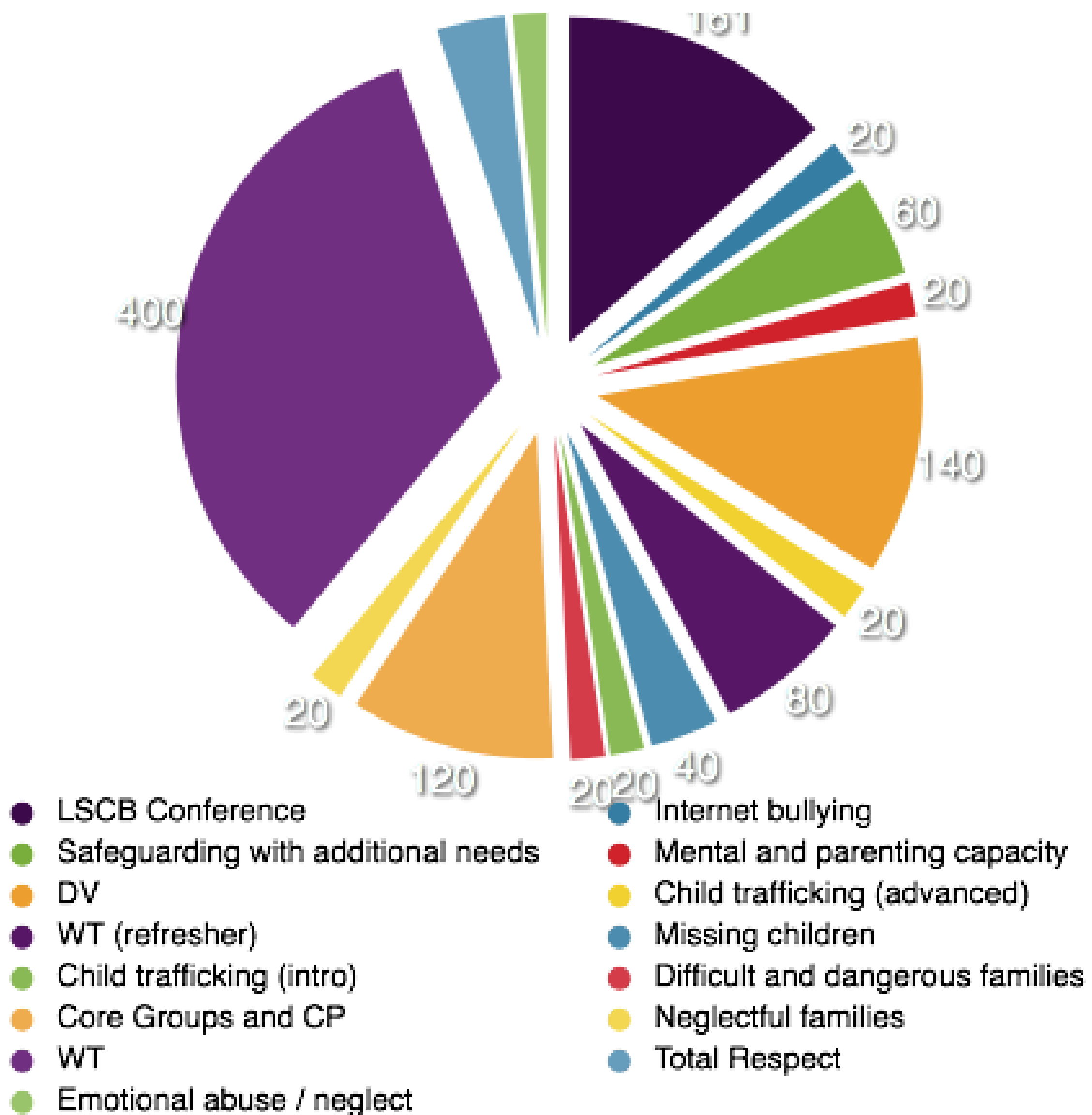
Staff often had to wait several months to get onto *Working Together to Safeguard Children Courses* (WT) and it is therefore worrying that a considerable number of learners (26.3%) cancelled their places or did not arrive (24.2%) resulting in a net waste of 37.5%. The drivers behind this need to be better understood and the training sub-group is investigating the data in more depth to advise the Board about possible remedial action.

Before 2011, WT was presented over two consecutive days which was practically difficult and expensive. The course is now presented on two different days with the second day designed as a separate, more advanced course, (Core Groups and Child Protection Plans) which are available to practitioners who are likely to participate in multi-agency safeguarding arrangements such as CiN / CP meetings. This has brought about a saving of about 280 course placements and fewer facilitators; evaluations show that this format is preferable to the previous arrangement.

APPENDIX A

Agencies

LSCB partners were well represented on training. The bulk of places (46%) were taken up by the various departments of the Local Authority e.g. children's centres. Schools, Hillingdon Health and Hillingdon Hospital were also well represented. More work needs to be done to engage the private and voluntary sector, police and GPs.



Courses

Apart from the courses already discussed, the Safeguarding Board also provided the following training days (presented by number of bookings)

5th Annual LSCB Conference

161 people from a wide range of agencies booked onto 2011/12 LSCB conference. It was especially positive to see agencies who do not regularly attend other board training, e.g. Police and UKBA but also foster carers, child minders and other workers in the private and voluntary sector. This year there were four speakers:

APPENDIX A

- Sue Jago (Metropolitan Police) who spoke about the learning from Operation Retriever and highlighted the issues and difficulties faced in identifying and supporting exploited children.
- James Blewett (King's College) who presented the Social Care Institute of Excellence's model for management reviews and highlighted the different approach this takes from the previous Serious Case Review model
- Detective Superintendent Dick Henson (Child Abuse Investigation) presented the Child Risk Assessment Matrix. Using the details of the Baby Peter case he demonstrated how this model could help alert practitioners to the early identification of unacceptable risk.
- Camila Batmanghelidjh from Kids Company who spoke about the work of her organisation Kids Company in developing relationships with young people.

Capacity

The increased levels of child protection activity have placed extreme demands on all agencies, particularly social care. Recent internal audits indicate how hard it is to maintain the standard of work in the face of this bombardment. Unfortunately, the hoped for improvement in stability of the social work staffing has not been realised. Turnover has remained comparatively high and there appears to be poor retention of new staff. In addition some key front line management posts are covered by locum staff. The Council has increased establishment in the front line teams by 5 senior social workers, 1 team manager, and the conversion of 3 family support to social work posts. A further 4 temporary posts were agreed in December 2011. However, the problem of filling these posts remains. A national recruitment campaign is planned, and an online confidential questionnaire has been developed in order to gather staff views about recruitment and retention.

Allegations against Professionals

The Local Authority Designated Officer (LADO) reported a continued increase in the number of referrals –up to 90 requiring a formal strategy meeting in 2011-12. They were from a wide range of agencies, particularly schools. During this period 9 referrals were supported to the Independent Safeguarding Authority (ISA) and there have been 3 criminal convictions of staff working with children, and 2 court cases pending. The LADO has also worked with the Police Integrity Assurance Unit in disciplinary hearings involving potential police officer misconduct. This has been a very welcome development in the working arrangements with Police.

Following the SCR involving schools in 2010, Hillingdon schools funded a full time post. This, together with the number of allegations referred, shows a strong willingness on the part of all schools in Hillingdon to ensure the safeguarding of their pupils. During the year a Safeguarding Schools Cluster Group was established in one part of the Borough to discuss joint issues of concern in relation to child protection, or children's' welfare. This has been

very successful, and has included academies as well as maintained schools. These will be rolled out across the whole Borough in 2012-13.

Many allegations were unsubstantiated, but almost all revealed learning points in respect of safe working practices, which could be followed up within the services concerned. There were no emerging themes but there was a continued trend of online and internet abuse being a significant aspect of the work. The increased number of referrals and allegations can partly be attributed to more consistent reporting of incidents that would previously have been dealt with by agencies internal processes, without the useful checks and balances and quality assurance processes provided by the LADO.

During 2012-13 plans include :

- Roll out of schools clusters across the whole Borough
- Improvements in procedures and recording systems
- Increasing awareness within faith communities
- Ensure that all agencies are aware of the impact of development of the new Disclosure and Barring Service
- Continued work with schools to ensure safe working practices in all schools

Stakeholder day

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

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

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

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

APPENDIX A

- Multi agency training was acknowledged to be high quality but more specialist training was requested on key areas. *NB. It should be noted that some training on these areas sometimes have to be cancelled due to lack of take up. The reasons for this are understandable capacity issues*
- A request for improved communication about important safeguarding issues

The first three points should be picked up through the developing Preventative Hub and Families services. The others are developed through the LSCB action plan.

APPENDIX A

5. 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 24 open actions on the PIP. During the year a further 125 actions were added, (c.f. 114 in 2010/11). These included 33 actions to assess the measurable outcomes from the SCR, 19 from the Ofsted inspection, 32 from the YOS inspection and 18 from the SCIE analysis. 122 actions were completed, leaving 27 open at the year end.

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. These are reviewed by the performance sub group. Following the serious case review schools are now asked to complete an annual safeguarding audit for the LSCB. These are reviewed by the Education officer and reported to the LSCB.

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

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

Effectiveness of local arrangements to safeguard children

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

Inspections and other external validation

In late 2011 Hillingdon volunteered to be part of a pilot inspection to test out the new Ofsted framework. Ofsted were using a new methodology, which followed cases from the front desk. A meeting took place with Ofsted to discuss the inspection and the lessons to be learned regarding the new methodology. There were some flaws in the inspection and managers felt they

did not have long enough with the inspectors. Governance and leadership was judged to be good and the accountability structure between the DCS, members and managers was judged to be outstanding. The inspectors had concerns regarding the quality of Hillingdon's recording of supervision, but were happy with the POD (group supervision) system. The unrelenting pressure at the Duty Desk was noted. Overall effectiveness and quality of practice was judged to be satisfactory, which was disappointing in view of previous good unannounced inspections. One consequence from the inspection has been a rise in the number of Section 47s and case conferences, which is testing all resources (see below). This has impacted on all agencies, though the inspection was very Council focused. Actions were taken immediately to respond to the findings and are being monitored through regular audit.

Child protection activity

Comparative numbers of conferences: 2011 and 2012		
Year (January-June)	2011	2012
CP case conferences	412	717

There has been a continued increase in the work referred into social care. There has been a 17% increase in referrals, 20% increase in initial assessments, 69% increase in core assessments, and 78% increase in child protection enquiries. There is no evidence of any reduction in thresholds. Not surprisingly, there has been a deterioration in percentage of assessments completed within timescale.

Over the last three years, there has been a gradual increase in the proportion of contacts that become referrals (38% in 2011-12) although a reduction in the proportion of referrals that then become subject to an initial assessment.

All referrals by age group	**2009-10**	**2010-11**	**2011-12**
Under 1	9.21%	10.65%	8.86%
1-4	22.83%	23.07%	24.97%
5-9	22.14%	24.69%	26.62%
10-12	14.77%	12.49%	14.65%
13-15	17.59%	16.59%	16.07%
16-17	13.34%	12.49%	8.83%
18+	0.12%	0.04%	0.00%

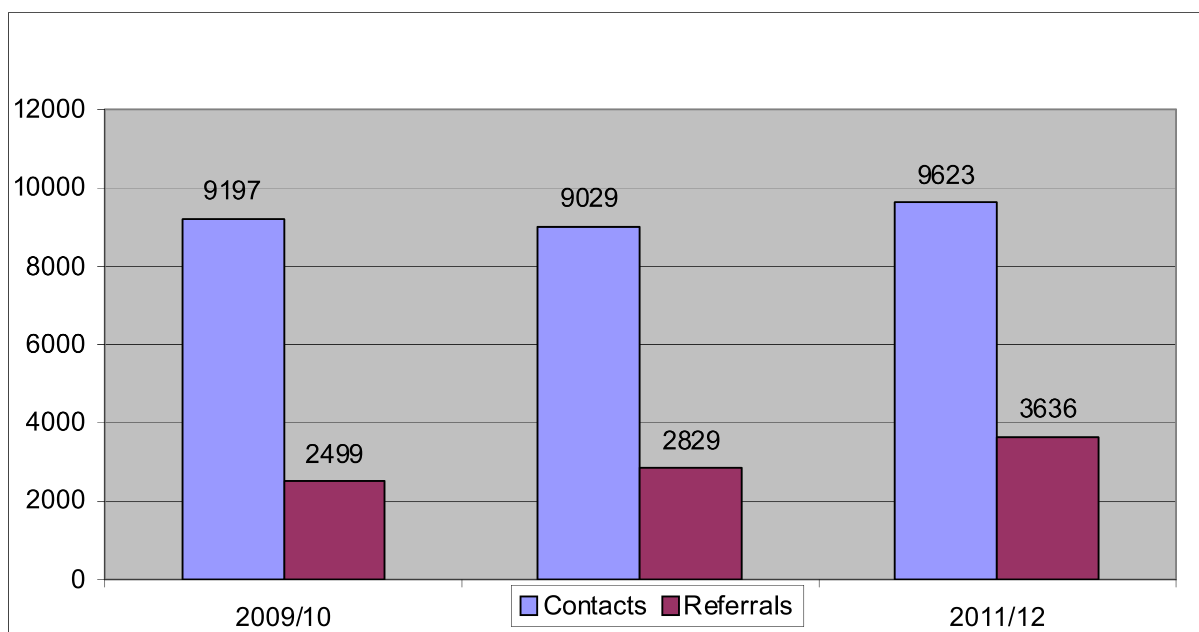
Overall, there is a greater increase in younger the age group being referred. This suggests that professionals and families are identifying problems earlier, which will make it easier to intervene effectively to produce better outcomes; especially once the children's pathway is fully developed in the Borough in the autumn of 2012 identifying problems earlier.

APPENDIX A

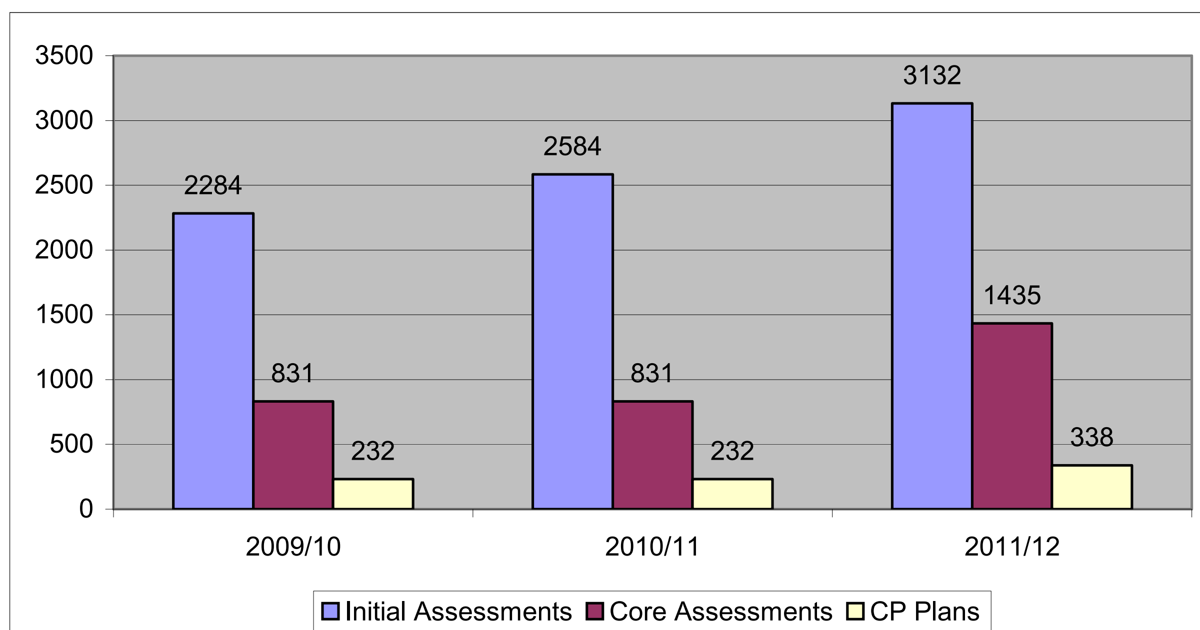
Referrals and re-referrals			
	2009-10	**20010-11**	**2011-12**
Referrals by year	2444	2779	3024
Re-referrals by year	366	518	644
Percentage re-referrals	14.98%	18.64%	21.30%

Over the past two years there has been a significant increase in the number and ratio of repeat referrals. Case audits conducted during the time of the Ofsted pilot inspection, indicates that this is an area of concern as the repeat referrals are tending to be an escalation of incidents of domestic abuse where children's development is being directly threatened or put at risk. This has been picked up in the LSCB business plan for the current year with an increased focus on early intervention in relation to domestic violence through the IDVA service , and allied agencies.

N.B. Please note that these figures are for year-by-year comparison only. They are raw data reported directly from ICS Protocol and may differ slightly from figures given elsewhere.



APPENDIX A



The number of children on child protection plans has risen from 232 in April 2011 to 251 at similar period in 2012.

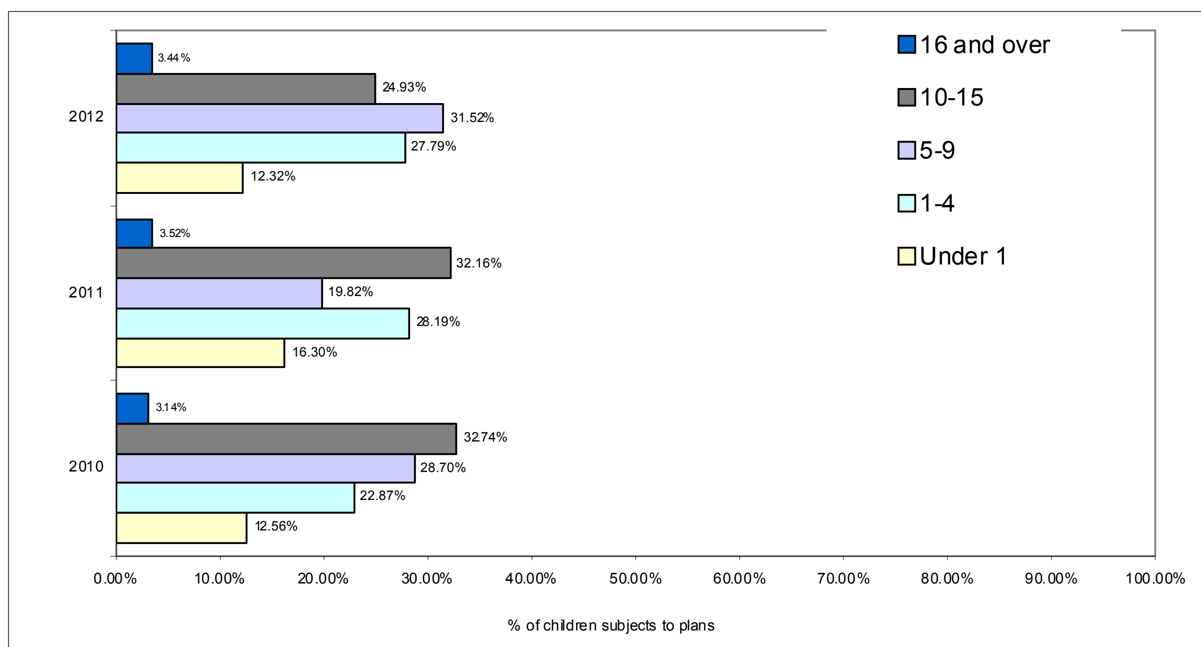
Although there has been a very small reduction in the number of children in care (due to reduction in number of asylum seekers) There has been a continued increase in the number of care proceedings initiated reflecting the national trend. Clearly appropriate action is being taken in the case of those families where children are likely to remain at risk of significant harm.

This increased activity is felt throughout the system as there is a consequential increase in workload across all agencies.

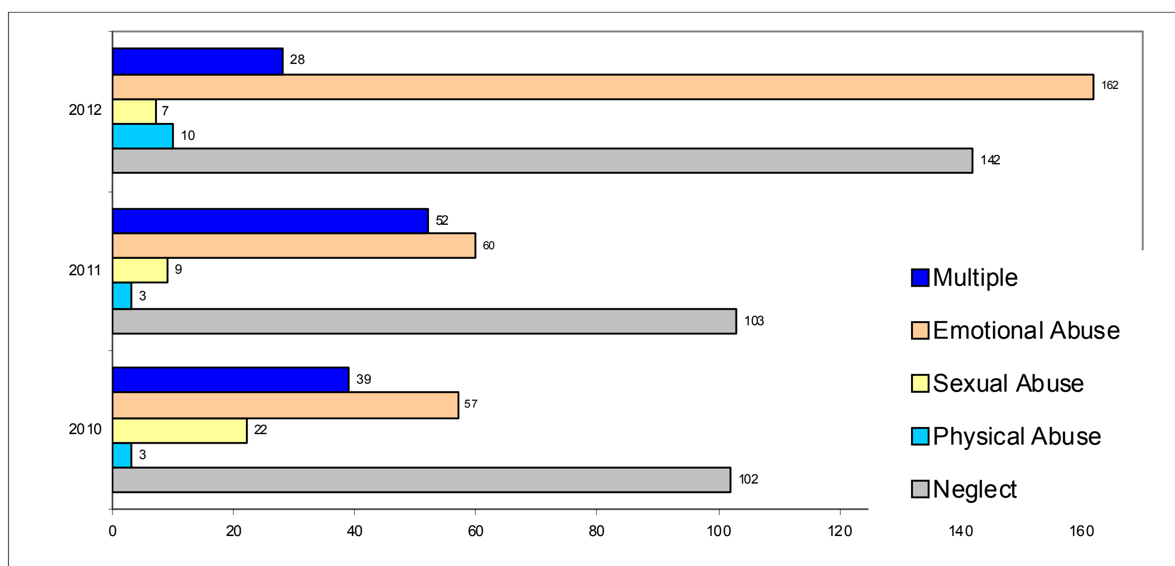
At the same time, the difficulties in arranging conferences and core groups has stretched the collaborative working between agencies, and with families.

During 2011-12 there was an increase in the proportion of primary age children subject to child protection plans, although there had been a reduction in the previous year. Certainly over the last few years anecdotal evidence from those working with this age group indicated an increase in assessed risk.

APPENDIX A



Of greater potential significance is the category recorded as reason for the plan. In 2011-12 there was an increase in the proportion recorded with neglect and/or emotional abuse as the reason. Within this, the proportion with emotional abuse has increased. We cannot be sure whether this is an actual increase or a greatly increased awareness. But, either way, it reflects a huge need for services to support these children.



Trafficked Children

The Local Safeguarding Children Board sub-group dealing with exploited and trafficked children has continued to thrive. Membership includes representatives from national government organisations, such as End Child Prostitution & Trafficking (ECPAT) and the Child Exploitation & Online Protection Service (CEOP). The co-operation of UK Border Agency staff has

been crucial in ensuring the effective screening of children for issues of trafficking, arriving at Heathrow Airport, and UK Border Agency also remains a pro-active member of the sub-group.

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

The model of collaborative work across agencies in Hillingdon was commended in a number of Home Office documents during the year, including the National Strategy for Child Trafficking and also national guidance on working with trafficked children. Human Trafficking: The Government's Strategy

The other operational group which sits beneath the Trafficking Sub-Group is the multi-agency meeting that addresses issues relating to children who are reported missing within the community. This group includes active involvement from the Public Protection Desk of the Borough Police, and also has engagement from the Youth Offending Service, as well as the front line social work teams and registered care managers of children's homes in the locality. This meeting has identified a small cohort of approximately fifteen children (mainly local children) who lead risky lifestyles through repeated episodes of being missing from home or care. The operational group has focused on collaborative interventions and has ensured that proper risk assessments are undertaken with this group of children. The work undertaken on missing children has been recognised at a national level and included an invitation to provide evidence to an All-Parliamentary Select Committee in February 2012, on the subject of children missing from home or care. Report from the Joint Enquiry into Children Who Go Missing from Care

Also in February 2012, the London Borough of Hillingdon hosted a visit from Norwegian social workers, keen to learn from our experiences of safeguarding trafficked children. This is indicative of the global nature of child trafficking as a child abuse issue for practitioners worldwide. Hillingdon's reputation as a bastion of good practice is now well known outside the UK and the high number of weekly 'hits' on the LSCB website child trafficking page, shows the universal and important nature of Hillingdon's work in this key area of practice.

Overall, the number of children going missing throughout the year has declined from eight to four young people who have not been located after arrival at the airport.

APPENDIX A

Private Fostering

The number of children in private fostering during the year has been relatively low (6) and represents an ongoing area for development. The Local Safeguarding Children Board has continued to deliver briefings and multi-agency training on the need to identify situations of private fostering. This has been beneficial for UK Border Agency staff at the airport terminals who have been able to notify local authorities other than Hillingdon, when children are being placed in private fostering situations across the UK.

In Hillingdon itself, there are more than ninety schools, including academies and independent schools. The challenge, given to head teachers, has been for each school to examine its admissions roll, and identify at least one child who is being privately fostered. This is work in progress and so far, has not yet resulted in additional notifications of private fostering situations. The research evidence shows that private fostering is often a key safeguarding issue for profiling children at risk of trafficking, child sexual exploitation and exposure to domestic servitude or exploitation in the catering industry. This remains a priority for the Local Safeguarding Children Board.

Disabled Children

The levels of awareness about child protection and child safeguarding within the Children with Disabilities Service has continued to grow during the course of the year. Although the number of children with disabilities who are subject to a child protection plan is still not growing sufficiently to demonstrate that this vulnerable group of children are being adequately protected, there is still nevertheless a rise in numbers. During 2011/12 there were ten or more children subject to a child protection plan who are known to the Children with Disabilities Team. This is significantly more than previous years.

Further case audits will be programmed to focus on the activities in the Children with Disabilities Team, (e.g., OT assessments) which should help to identify issues of neglect or poor standards of physical care for children with disabilities, which may be reaching the threshold of significant harm. The learning from this case auditing activity will be fed back to the managers within the Children with Disabilities Service and Special Needs Service to continue the trend for better identification of child protection issues, within these vulnerabilities.

Looked after children

During the course of the year, the number of looked after children within the borough has remained relatively constant (378). Despite the downward trend of asylum seeking children who are becoming looked after, the numbers of children coming into care has not reduced at the levels anticipated. This is primarily because the child protection and safeguarding issues relating to younger, more vulnerable children, especially those exposed to domestic violence, has meant that more legal interventions have been required. During the course of the year, there were forty-five sets of care proceedings, instigated by the local authority involving eighty-nine children. In addition, a significant number of children are subject to the Public Law Outline. This increase in legal intervention shows that child abuse is being identified by professionals and action is being taken to ensure protective arrangements are

in place, by bringing children into the care system if required. The aim in the next year (2012-2013) is to ensure a more focused use of family group conferencing, to enable older children who have come into care as a result of family breakdown to be rehabilitated safely with a package of intensive family support.

The issues relating to looked after children placed out of borough is also a concern, as it has proven difficult to engage partner agencies in safeguarding children outside the locality. This is especially true in relation to children who are reported missing outside the borough and children who may be engaged in low key but significant criminal activity. The issue of monitoring looked after children placed out of the borough was picked up at the All-Parliamentary Select Committee, at which Hillingdon gave evidence in February 2012. It is anticipated that there will be firmer arrangements for ensuring notifications around children placed outside the authority with stronger national guidance from Central Government to make sure that the host authority takes responsibility for safeguarding actions to protect looked after children in their locality.

Young carers

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

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

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

Space is a young carers project that specifically supports children and young people between the ages of 5-18 living in Hillingdon who are for a family member with a drug and/or alcohol problem.

Year	Young carers	Carers in Space project
2010-11	273	131
2011-12	298	130
percentage increase	10.9%	n/a

Since the project started in 2007 there has been a year on year increase, average of 10% per 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. (Last year's entry)

It was noted that 50% of young carers are part of a family where there are adult mental health issues. Over 70% of families with alcohol/substance misuse issues are single parent families, where children are not being parented as well as they might be. When a referral is made, not all young carers receive a CAF; a lot of young carers are children in need, with 25% being subject to child protection. The young carers outside of these groups are those raising concerns. (report from carers lead at SAPB)

Children who experience domestic violence

These continue to form a high proportion of those with child protection plans, and many of them also come from families where substance misuse and/or metal illness are present.

The annual returns from the Hillingdon Independent Domestic Violence Project (HIDVAP) show that they received 645 referrals during they year, of which 88% engaged with the service to some degree. 97% of referrals were female, and 20% were 16-20 years of age

These referrals involved 689 children. 52% of victims said their children had witnessed abuse, and 22% that children had experienced abuse themselves. 23% had experienced violence during pregnancy

The ethnicity of referrals were consistent with the Borough population but approximately 9% experienced honour based actual or feared violence or forced marriage. This is quite a significant number.

A large proportion of interventions relate to criminal or civil law and housing response. Only a very small number of families end up in a refuge and about one fifth receive health and well being support. 95 families in the year were referred on to/received social care services, which potentially indicate high levels of child protection concerns

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

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

Child Abuse Investigation Team (CAIT)

The target for overall sanction detection performance in 2011/12 was 22%. Hillingdon CAITs (covering Ealing and Hillingdon Boroughs) SD performance at the year end was a rate of 26%, detecting 144 out of 544 offences.

APPENDIX A

The target for rape sanction detections performance in 2011/12 was 42%. Hillingdon CAITs SD performance at the year end was a rate of 27%, detecting 7 out of 26 offences.

All the investigations that did not lead to a prosecution were reviewed to ensure that the welfare and safety of the victims were prioritised and always considered in the decisions made, and that all possible lines of enquiry were considered and followed in the search for evidence.

Several of the 19 ‘not proceeded with’ on the two Boroughs were historic and this does throw up specific challenges over the requirement to meet the very high evidential threshold for the Crown Prosecution Service to charge.

6 cases involved adult victims that had significant mental health issues; this resulted in the victim’s being unable to provide any evidence.

Other targets for the CAITs are around attendance at Case Conferences and Review Case Conferences (RCC). The target is to attend 100% of initial Case Conferences (met by Hillingdon CAIT) and 50% of Review Case Conferences; 77% of Hillingdon’s RCCs were attended by CAIT.

Other measures for the Police CAIT are recorded as National Safeguarding Measures and based on nationally agreed criteria amongst all police forces in England and Wales. These measures include how quickly referrals or requests for information are dealt with by way of strategy discussion and action, and identifying what the decision is in regards to single or joint agency investigation.

No set targets exist as of yet, but the rationale for these national measures is to monitor consistency across the 16 CAITs in London, and to compare with Forces elsewhere in England and Wales.

Currently, the data has not been collected for long enough to enable analysts to make a clear interpretation on performance.

Youth Offending Service

In July 2011 Hillingdon YOS was subject to a Core Case Inspection by her Majesty’s Inspectorate of Prisons. The inspection team identified that the quality of safeguarding work undertaken by the team required improvement particularly with respect to the quality of assessments, intervention planning, reviewing of cases and management oversight.

The report did highlight some strengths noting that;

- where required all necessary action was taken to safeguard and protect children and young people from immediate risk of harm and
- there was evidence of effective joint working between YOS workers and children’s social care to promote Safeguarding and well being of children and young people.

The timing of the inspection meant that the effect of changes already implemented by the team earlier in the year, had no impact on the activity being reviewed. The YOS built on those changes in developing its inspection improvement plan which is being overseen by the YOS Management Board and includes the following activities;

- The development of an integrated planning framework
- The introduction of an integrated planning and review forum
- Quality audits of assessments and interventions plans followed by staff training and development activity.

Over 90% of the actions in the improvement plan have been completed and the outstanding activity focuses on evaluating the impact of the systemic changes and training on the quality of the assessments and intervention plans.

The Safeguarding and Quality Assurance team have also been involved in case file auditing for the YOS introducing a degree of independence into the process.

Potential risks to safeguarding

Resources. The biggest risk, as ever, is the availability of staffing capacity when measured against workload. Although some 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. Social care has not been able to improve the stability of the workforce as had been hoped at the start of the year. 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. All the key statutory agencies are carrying out some reorganisation to comply with Government requirements and to improve 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. Considerable work has been done to develop and improve Council early intervention services, the fruits of which will be seen in 2012-13. 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 more case reviews this year 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 Pathway Programme and 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.

New safeguarding inspection framework. During 2012 Ofsted is inspecting under a revised framework that is based on the Munro report, is unannounced, and based more on the child's journey. Hillingdon was one of six areas piloting this approach. There are indications from those inspections already carried out that it is a harder test, and focused almost entirely on local authorities. A more extensive joint multi agency format has been published for consultation.

Hillingdon Council is building a culture of continuous quality oversight and improvement based on the inspection standards, and this will be augmented by the LSCB quality assurance framework. This work is supported by the appointment of a specialist quality assurance manager.

APPENDIX A

6. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

The Munro review and revised Working together to Safeguard Children

In 2011 the Government accepted the main recommendations from Professor Munro's report, which required a considerable change in operating culture. New frameworks for performance monitoring and inspection have been developed. Reforms for social work have been implemented and each local authority has a designated principal social worker to support practice. In order to support more local decision making and development it has been decided that the national eCAF system will be decommissioned, although use of the Common Assessment Framework continues to be encouraged. The Government has decided that a new statutory duty on delivering early help is not needed, as there is sufficient existing legislation to deliver this.

However, the biggest changes will be delivered through three new documents, published in summer 2012 for consultation. The New Working Together to Safeguarding Children is radically reduced in size and focused purely on statutory requirements. Statutory Guidance on learning and Improvement outlines new arrangements on Serious Case Reviews using systems methodology, along with reviews of child deaths and other learning processes led by LSCBs. Draft guidance on Managing Cases: the Framework for the Assessment of Children in Need and their Families proposes a more continuous assessment process that is not constrained by national timescales for completion.

Although some of the revised guidance is welcomed, it imposes major challenges on local areas, and London, for developing local frameworks that are 'timely, transparent, and proportionate to need'

National Health Service

It has been a year of significant organisational transition for the NHS. Public Health which leads on commissioning will move to the Local Authority in April 2013 but its safeguarding role in the Local Authority has not yet been defined in central guidance. It is anticipated, although the central guidance has not yet been issued, that the management of the designated doctor and nurse will move to the CCG as part of the transition arrangements.

The CCG is acting in shadow form in 2012/13 and is expected to obtain its authorisation during 2012/13. The Board will need to work closely with GPs both as commissioners i.e. their CCG role and providers.

During 2012/13, a regular meeting of all NHS commissioners and providers was held, convened by the PCT (Public Health) in order to try to ensure the continued good co-ordination of services through the transition period.
There was an increase in NHS workload during 2012/13 as was also experienced in LBH. This required some reprioritisation of children's services so that the demand could be met.

The new GP led Clinical Commissioning groups will be fully operational from spring 2013. In the meantime a shadow CCG is in place in Hillingdon. A key

task for the LSCB will be to secure the engagement of GPs as both commissioners and providers of services.

Education changes

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

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

APPENDIX A

7. WHAT WE NEED TO DO: priorities for LSCB 2012 onwards

Our evaluation of the progress against our priorities plus our assessment of the effectiveness of local safeguarding arrangements, consideration of relevant national issues, and feedback from staff has led us to identify the following main priorities for the Board's work from 2012.

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

Priority 1 Improve LSCB functioning

- Continue to implement Munro recommendations and Government requirements as required, particularly updated Working Together and related guidance.
- Carry out a section 11 audit across agencies
- Fully develop and implement the Quality assurance framework
- Rationalise the performance information produced by social care and the Children's Trust, and feed into improved data framework for the LSCB
- Incorporate views of children, young people and their families in the work of the LSCB through response to Borough survey, views of those on cp plans
- Incorporate the views of staff in the work of the LSCB though responses at stakeholder day and questionnaire
- Appoint lay members to the Board
- Improve engagement with GPs and Clinical Commissioning group
- Continue to develop ongoing communication with front line staff (newsletter/stakeholder days)

Priority 2 Assess and improve operational practice

- Ensure all agencies fully understand the social care threshold criteria, and that it is embedded in the development of preventative services
- Improve the oversight of single agency audits
- Develop and learn from a multi-agency quality audit programme for the LSCB
- Roll out the schools safeguarding clusters across whole Borough (3 more clusters)

APPENDIX A

Priority 3 Improve outcomes for children affected by key risk issues

- Improve the identification and support for children and young people involved in sexual exploitation
- Improve the identification and support for children and young people involved in gang activity
- Improve quality of information sharing and risk assessments for children and young people who go missing, particularly looked after children
- Continue to try and benefit from funding opportunities for children and young people affected by domestic violence
- Improve the effectiveness of joint working across children's and adult services in respect of mental health and substance misuse issues
- To raise awareness of child abuse linked to faith or belief

Priority 4 Ensure a safe workforce

- Carry out and respond to audit of single agency training
- Develop ways of assessing access to and impact of training
- Enhance support to front line managers
- Look at more creative ways to improve access to and attendance at multi agency training
- Continue to improve responses to allegations against staff
- Ensure compliance with new legislation and guidance around recruitment

Priority 5 Learn from Case Reviews

- Implement learning from management reviews
- Complete implementation of the actions arising from the SCIE pilot
- Continue to implement learning from unexpected child deaths and disseminate key messages to local professionals

APPENDIX A

8. CONCLUSIONS AND RECOMMENDATIONS TO THE CHILDREN'S TRUST

There is a commendable commitment by all agencies in Hillingdon to keep children safe. Each agency is trying to monitor its own practice, and the LSCB is improving its quality assurance mechanisms in order to assess multi agency practice. Our current assessment is that multi agency working is generally good, but there are several major risks to this. Workload and staffing are the biggest risks, along with the pressure on resources in the context of increasing demand and all agencies are experiencing the potential of disruption of reorganisations. In this climate, it is vital that all agencies and staff resist the temptation to retreat to their own silos and continue to develop opportunities to work together, to share information, and to respect each others roles and viewpoints.

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. Child protection work has increased but a strong message coming from SCRs and research emphasises risks to very young children, and those at risk of long term neglect. 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.

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.

The significant increase in child protection activity and increase in those subject to care proceedings indicates appropriate awareness of risks to children and action to protect them. However, the impact poses inevitable risks to the quality of work to keep children safe. All agencies are struggling to respond to this increased need with existing capacity. This risk is exacerbated by the lack of stability in social work teams both at practitioner and manager level. London is a competitive market, and the work is hard and stressful. The Council is therefore urged to consider the possibility of increased staffing along with recruitment and retention incentives

This pressure reduces the availability of time to work with cases of children in need who fall below the threshold of child protection. Many of these are likely to be long term neglect cases that require careful monitoring and support to avoid future risk. The Council led initiative of a preventative hub and pathways for vulnerable children, alongside the Hillingdon Family Service and Multi Agency safeguarding Hub, is therefore welcomed. However, these initiatives are not yet fully multi agency. Partner agencies are experiencing their own capacity issues, so it is vital that these services are developed in **full** partnership with other agencies, both child and adult

APPENDIX A

Linked to that is the importance of services for children who experience emotional harm , including those abused, exploited or affected by domestic violence. National prevalence figures suggest that there are likely to be between 6000 and 13,000 children and young people in Hillingdon who experience mental health problems at some time. There has been a rise locally in numbers exhibiting ‘risky behaviours’ –behaviour problems, school exclusions etc. Local needs analysis suggests a comparatively high spend on tier 4 and low spend on early intervention services. (JSNA) This issue has been further highlighted recently by the Layard Report which highlighted the importance and lack of mental health treatment nationally, particularly psychological therapies (both adults and children) Comments have already been made about the comparative low level of CAMHS 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.

The need for improved services to support these children must be considered by the relevant commissioners.

APPENDIX A

9. APPENDIX 1: LSCB membership

Chairman and officers of the LSCB

- Lynda Crellin - Chairman [Independent]
- Maria O'Brien - Deputy Chairman [Managing Director, Community Services, CNWL NHS Foundation 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
- Lynn Hawes - Service Manager, Youth Offending Service, Social Care, Health & Housing
- Nick Ellender - Service Manager, Safeguarding Adults, Social Care, Health & Housing
- Dawn France - HR

Health representatives

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

Police and probation representatives

- Tariq Sarwar - Detective Chief Inspector, Hillingdon Borough Police
- Dave Franklin - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police

APPENDIX A

- Sharon Brookes - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
- Marcia Whyte – 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 Millar - Children, Youth and Families Officer, Hillingdon Association of Voluntary Services
- John Walsh - Service Manager, CAFCASS
- Danielle Lambert – Regional Director, UKBA
- Chris Condon – Projects Officer

APPENDIX A

10. APPENDIX 2: Glossary

A&E	Accident and Emergency Services
CAF	Common Assessment Framework
CAIT	Child Abuse Investigation Team (Metropolitan Police)
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CNWL	Central and North West London Trust
CIN	Children in Need (sec 17 Children Act)
CP	Child Protection
DCS	Director of Children's Services
DfE	Department of Education
DPH	Director of Public Health
GP	General Practitioner
HCFTB	Hillingdon Children and Families Trust Board
HCH	Hillingdon Community Health
HMIP	Her Majesty's Inspector of Prisons
ICT	Information and Communication Technology
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Analysis
LADO	Local Authority Designated Officer (allegations against staff)
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
LSP	Local Strategic Partnership
NSPCC	National Society for Prevention of Cruelty to Children
NPIA	National Policing Improvement Agency

APPENDIX A

PIP	Partnership Improvement Plan
PCT	Primary Care Trust
PEECS	Planning, Environmental, Education Community Services
SAPB	Safer Adults Partnership Board
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SEN	Special Educational Need
SIT	Safeguarding Improvement Team (NHS London)
THH	The Hillingdon Hospital
YOS	Youth Offending Service
UKBA	United Kingdom Border Agency

APPENDIX A

11. APPENDIX 3: LSCB Budget

Income 2011-12

Health	£60,000.00
Local Authority	£61,000.00
Metropolitan Police	£5,000.00
UK Border Agency	£5,000.00
Probation	£2,000.00
CAFCASS	£565.00
Government Grant [Munro funding]	£29,000.00
TOTAL	£162,565.00

Outgoings 2011-12

Staffing	£90,000.00
LSCB Chairman	£23,000.00
Consultancy [PIP management & website]	£9,000.00
Independent reviewer [SCIE Pilot]	£11,000.00
e-Learning training licence	£7,000.00
Office running costs [stationery/telephone etc]	£2,500.00
Catering – LSCB conference	£5,000.00
TOTAL	£146,500.00

The balance of £16,665 has been rolled over to the current financial year to pay for Independent multi-agency case reviews and section 11 audit prioritised by the 2012-2013 LSCB Business Plan.