

# HILLINGDON LOCAL SAFEGUARDING CHILDREN BOARD

## ANNUAL REPORT

2013-14

### EXECUTIVE SUMMARY

#### **Background:**

This report covers the work of the Hillingdon LSCB for the year 2013/4. It highlights the main achievements in safeguarding Hillingdon's children and young people and identifies the priorities for the following year and beyond.

The Hillingdon LSCB is the key statutory mechanism for agreeing how the relevant organisations in Hillingdon cooperate to safeguard and promote the welfare of children and for ensuring the effectiveness of what they do.

The purpose of the report is to critically analyse and report on the previous year's performance and to set out the Board's priorities and plans for the following year.

In December 2013 Children's Social Care and the LSCB were inspected by Ofsted. The Board had, just prior to this, commissioned an independent review of its structure and operations.

Although many strengths were identified both the Board and Children's Social Care were graded as "Requires Improvement".

#### **Summary:**

The year has been characterised by the consolidation of change and upheaval in partner organisations, alongside continued reorganisation within Council services for children.

Although the number of children subject to child protection plans has stabilised. It has been at a higher level than in previous years and workloads have remained high. There is evidence of strong practice in many areas but the challenging problems of domestic violence, mental health problems among both parents and children and difficulties in identifying and resolving long-standing neglect remain. In addition national and local cases have continued to focus our minds on important issues such as sexual abuse and exploitation.

#### **The Priorities for 2013/4, what they were and what we did:**

Priority 1: Improve LSCB functioning

- Working Together 2013 was adopted
- Revised London Child Protection Procedures were adopted
- A limited survey of the views of young people undertaken
- A Business and Improvement Plan was agreed
- Early Help assessment model was adopted

Signs of Safety conference model was implemented.  
An on-line staff survey was undertaken in 2013.  
Safeguarding training was provided to 70 staff and volunteers in 6 mosques and madrassahs.  
A named safeguarding GP was appointed who runs weekly sessions with children.  
Head teacher groups represented on LSCB.

Priority 2: Assess and improve operational practice.

The London Board threshold of need was adopted.  
A single assessment process was launched in November 2013.  
A quality audit programme was initiated and some auditing undertaken  
Single agency audits were undertaken for the work of the year for reporting in this Annual Report.

Priority 3: Improve outcomes for children affected by key risk issues

Operational practice regarding children trafficked has been monitored through a joint group with Heathrow. This work has been commended by the Office of the Children's Commissioner.  
Systems were put in place to monitor those young people thought to be at risk of Child Sexual Exploitation (CSE), this led to arrests and a successful prosecution.  
Services to children affected by domestic abuse were reviewed and the Multi-agency Risk Assessment Conference (MARAC) arrangements were commended by Ofsted.  
Increased awareness among young people and their parents of e-safety via cyber-mentoring and a newsletter for schools.  
Improved scrutiny of children living in a home where there is acute mental illness or substance misuse via a joint protocol between adult and children's services.

Priority 4: Ensure a safe workforce:

An e-learning module on safer recruitment was rolled out.  
A pilot was undertaken on assessing the impact of learning and a recommendation made to the LSCB that this should be rolled out.  
Improve scrutiny of multi-agency training by a six-monthly report to the LSCB  
Strong promotion of the Local Authority Designated Officer (LADO) role to schools  
New guidance developed and agreed on DBS checks and the Protection of Freedoms Act. The website guidance was updated accordingly.

Priority 5: Learn from Serious Case Reviews:

The Child Death Overview Panel (CDOP), jointly arranged with Ealing has continued to operate effectively and to gain and disseminate learning.  
Sessions were delivered to staff on key issues from national Serious Case Reviews.

**Governance:**

The LSCB operated during 2013/4 in accordance with Working Together 2013. All statutory agencies have reported on their internal safeguarding governance arrangements. Over the year there were eleven sub-groups that covered specialist areas; this was reduced to four following the review. Attendance at meetings was broadly good, although capacity issues in some agencies put pressure on their attendance

**Financial Arrangements:**

All statutory Board partners provide funding and considerable "in-kind" contributions are made by Children's Social Care. However, the budget is under considerable pressure and a review of funding is urgent.

**The Effectiveness of Local Safeguarding Arrangements:**

The following are available to the LSCB as means of assessing the effectiveness of safeguarding in the Borough: A Partnership Improvement Plan (measures the actions from inspections and audits), Performance Profile, Business Plan and sub-group action plans and audits. All are considered by the Board throughout the year. In addition the Board considers the outcomes from partner regulator inspections.

**Statutory requirements**

The LSCB is required to assess the effectiveness of multi agency training. This is done through half- yearly reports from the training sub group so that the Board can have oversight of the multi agency training programme, which is generally evaluated highly, though our capacity to deliver is outstripped by demand.

The LSCB is also required to carry out Serious Case Reviews as necessary. None were held in 2013-14 although two, and a possible third, will be instigated in 2014-15. Two case reviews that did not meet SCR criteria were carried out alongside multi agency case audits. These were used to make recommendations to improve practice. The Child Death Overview Panel continued to operate effectively and lessons learnt were disseminated across the Borough.

**Potential risks to Safeguarding:**

At a time of austerity the resources available to each organisation are under pressure and partner agencies are reorganising in the light of this. Both bring their risks. The LSCB remains concerned about the lack of sufficient competent and permanent staff, particularly in social care, though notes that steps are being taken in 2014 to improve this. The LSCB has also identified a

lack of coordination of Early Intervention work and hopes to see an improvement in this over the forthcoming year as new developments take effect.

The presence of Heathrow in the Borough brings risks in respect of a transient population, particularly risk of trafficking, and exploitation. However, the tripartite relationship between the airport, LBH and the LSCB is an excellent one that works well to reduce the risks.

### **Potential Opportunities to Improve Safeguarding:**

In spite of the changes and staff turnover the children's workforce is known to be both skilled and committed, there is much evidence of good communication between agencies and good work undertaken with children, young people and their families. The development of the children's pathway programme and key worker system, supported by the shared assessment and referral process, should ensure better identification of the need for early help and allow for the coordination of early help services at the first possible opportunity.

The Signs of Safety conferencing arrangements are a proven way of improving assessments and properly involving families in the assessment process and the roll out of this in 2014 is a positive move. The LSCB has also been pleased to note the appointment of a dedicated quality assurance manager in Children's Social Care, which has brought an additional level of scrutiny to the agency.

### **Priorities for 2014 onwards:**

The "Requires Improvement" grading from Ofsted was accepted and considered to be realistic.

A Business Plan detailing the work in progress is available to all Board partners. It encompasses the improvement plan following the inspection by Ofsted and is reviewed at each Board meeting and, in detail, by the newly formed Executive group.

The action plan arising from the Ofsted inspection includes the following priorities for the LSCB in 2014-15

- Ensure that time allocated to LSCB meetings is sufficient for partners to effectively undertake its work.
- Improve the communication with other strategic bodies, including the Health and Wellbeing Board, to ensure strategies aiming to improve the lives of children and young people are effectively coordinated.
- Ensure that the LSCB effectively evaluates safeguarding performance through audit and performance monitoring of multi-agency activity, and make sure evaluation is used to improve services.
- Ensure that the LSCB provides effective challenge to partners and holds partners to account to improve safeguarding outcomes for children and young people.

- Ensure that children young people and the community are appropriately engaged in the work of the LSCB, strategically and operationally, so that its work reflects their views.
- Ensure that partners are appropriately engaged in developing and delivering multi agency aspects of the Signs of Safety approach to risk management, so that there is full multi agency engagement in identifying risks and strengths to keep children safe.
- Ensure that the impact and effectiveness of multi agency training is evaluated so that its effectiveness can be assessed and improved.

### **Issues for partners**

A significant challenge to improvement is the ongoing lack of permanent staff in Children's Social Care, however this has been addressed to some degree by the decision of the Council to bring in a managed social work service, it is hoped that this, together with a decrease in caseloads will enable social workers to improve the quality of assessment and Care planning for children in need and those looked after or leaving Care.

A small but significant increase in the number of cases referred to the Serious Case Review Panel indicates some concern about casework among vulnerable children and young people.

It is important that the work carried out on threshold and early intervention services improve the coordination of early intervention for families in need, and this must be backed up by the availability of services. Although there has been a strong commitment to the MASH from Children's Social Care and the police other agencies need to be fully engaged and the LSCB is keen to see an escalation of progress for this over the next period.

For some years the LSCB has expressed concern regarding the effectiveness of the local Child and Adolescent Mental Health Service (CAMHS), this concern is heightened by evidence in the current JSNA that the Borough has identified higher than average numbers of young people reporting to A & E after self-harm and alcohol misuse and a lower than average acceptance of referrals by CAMHS. Monitoring improvements in this area are of high priority for the LSCB.

The relationship between the schools and other education providers and the LSCB needs to develop further with a clear focus on all groups of vulnerable children and young people in, and out of, education.

The partnership with Health is a strong one but further work is needed with GPs as providers and with NHS England who are not represented on the Board.

There has been much positive work with Youth Offending, the Police and UKBF to identify and support young people at risk, we need to ensure that this continues and that the risks, including that from gang culture, are properly assessed.

There has been no reduction in the impact of some of the more intractable problems such as domestic violence, mental illness and substance misuse among parents, and some long-term neglect, often not identified until adolescence.

The LSCB itself has struggled to resource its work and an anticipated increase in Serious Case Reviews will require a review of the LSCB resourcing. This has also hampered the ability of the LSCB to undertake a full multi-agency training programme and the amount of auditing that we would have liked.

The LSCB is also concerned about the high levels of poverty in the Borough, particularly in the southern wards where over 40% of children and young people are deemed to live in poverty. The figure for the Borough as a whole is over 24% which is high for one of the more affluent London boroughs.

# Hillingdon Local Safeguarding Children Board Annual Report 2013 – 14

*‘That every child and young person is as safe and physically and emotionally secure as possible, by minimising risk of harm as much as we can.’*



# INDEX

1. INTRODUCTION .....	9
2. LOCAL POPULATION AND TRENDS.....	11
3. WHAT WE HAVE DONE .....	15
4. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS.....	20
5. LEARNING FROM CASE REVIEWS AND AUDITS .....	47
6. WORKFORCE .....	51
7. HOW WE ARE DOING: effectiveness of local safeguarding .....	55
8. NATIONAL AND LOCAL CONTEXT: implications for safeguarding .....	70
9. WHAT WE NEED TO DO: priorities for LSCB 2014 onwards.....	74
10. CONCLUSIONS AND ISSUES FOR THE CHILDREN'S TRUST AND OTHER BODIES.....	80
APPENDIX 1: LSCB membership.....	82
APPENDIX 2: Glossary.....	84
APPENDIX 3: LSCB Budget.....	86
APPENDIX 4: Performance Data .....	87



## 1 INTRODUCTION

This report covers the work of the Local Safeguarding Children Board (LSCB) during 2013-14, and any significant developments that took place in the early part of 2014-15. 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. All statistical information included covers the period April 2013 to end March 2014, but we have also included significant developments from the first half of 2014-15

The main purpose of the LSCB is laid out in 'Working Together to Safeguard Children' (HM Government 2013). It is the key statutory mechanism for agreeing how organisations in the area work together to safeguard and promote the welfare of local children, and for ensuring that they do so effectively. This latest version of the statutory guidance, based on the outcome of the Munro Review, was long awaited. This represented a radical shift in the way in which the child protection system operated in England. It includes a new approach to the oversight of Serious Case Reviews, new guidelines for assessing the needs of vulnerable children, and a huge reduction in the level of national child protection guidance.

The 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.

In December 2013 Hillingdon was inspected by Ofsted. We were among the first four authorities to be inspected under the new regime, which combined an inspection of local authority services for children in need of protection, looked after and adoption services, alongside a separate inspection of the LSCB for the first time. The judgement for both the local authority and the LSCB was 'requires improvement'. Many strengths were identified, along with areas for improvement of which we were aware. The implementation plan arising from that inspection has formed the basis for our business plan for 2014-15.

Coincidentally an independent review of the LSCB had been commissioned before we received notification of the Ofsted inspection. The review was carried out and confirmed in large part the Ofsted findings. Recommendations from the independent review have been incorporated into the implementation plan.

The year has been characterised by the consolidation of change and upheaval in partner organisations, alongside continued reorganisation within Council services for children.

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

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

**Lynda Crellin**

**Independent Chairman 2014**

## 2 LOCAL POPULATION AND TRENDS

Hillingdon is the second largest of London's 32 Boroughs. It had a population of approximately 273,900 at mid 2012 of which 26.2% were under 19. This proportion is slightly higher than England and London. There has been an actual and projected increase in numbers of very young children, and families with the 5-9 age group projected to rise the most over the next few years. However, these growth rates are not very different from London as a whole.

About 46% 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. 26.3% are Asian/Asian British, 11.1% Black or Black/British, 8.5% mixed. Thirty four languages were recorded in Hillingdon schools with just under 40% having a first language that is not English

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. Wards in the south of the Borough also have a much higher proportion of young people, and also much higher numbers who are not white British. 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.

**Child Population Profile:** There are significant variations in the population of children and young people across Hillingdon, with more younger people in the south of the Borough, and also higher proportions who are from ethnic minority groups (about 75% in Hayes and Harlington, compared to about 37% in Ruislip and Northwood). About 45% of children and young people in Hillingdon are White British, 26% Asian or Asian British groups, 11% Black or Black British groups, 9% in any Mixed group, 5% other White groups, and 4% in Other groups. Almost 40% of the school population do not have English as their first language. Over the last 10 years the proportion of children born to mothers who were born outside the UK has risen to over 50%, with the biggest increases in births to mothers born in Asia and the Middle East and in countries which joined the EU since 2004.

**Poverty:** Over a quarter of children aged 0-15 in Hillingdon are deemed to be living in poverty, including over 40% of children in several wards in the south of the Borough, and 19% of school age children are eligible for free school meals.

**Vulnerable Groups:** Some groups of children and young people are more vulnerable than others to poor health, educational and social outcomes. In Hillingdon 5,600 children were deemed to be in need throughout 2012/13, and this number has increased in each of the previous 3 years. The most common

primary need identified was abuse or neglect, followed by absent parenting which was the primary cause in almost 20%, probably related to the number of Unaccompanied Asylum Seekers who become the responsibility of Hillingdon Borough through Heathrow airport.

**Disabilities:** Around 8% of children in need in Hillingdon have a disability, the commonest being learning disabilities, mobility and communication problems. More data on childhood disability in Hillingdon is awaited, but estimates based on national data suggest that 3.0- 5.4% of children and young people (about 2,300 - 4,100) are likely to have some form of disability. Disabilities are more common among children from more deprived socioeconomic groups, and there are more boys than girls with disability at all ages.

**Education:** The January 2013 school census found that a total of 1,177 pupils attending Hillingdon schools (2.9% of the total school age population) had a statement of Special Educational Need (SEN), and 2,429 (6.5%) were subject to School Action Plus (meaning that the school receives external help for the child.) The commonest category of SEN is speech, language and communication needs and significant numbers also had behaviour, emotional and social difficulties, with smaller numbers with Dyslexia, moderate learning difficulty and Autistic Spectrum Disorder. In several wards in the south of the Borough and in Harefield over 24% of the school population were assessed as having SEN. Statemented pupils in Hillingdon appear to achieve less good educational outcomes than nationally, but this difference is much more marked at Key Stage 2 than at Key Stage 4. Children with some types of learning difficulty are also at significantly increased risk of mental health problems and estimates based on national research and local information suggest that 2.6% - 3.5% of children and young people aged 5-18 in Hillingdon will have both a learning difficulty and an emotional or mental health problem, equivalent to about 480-620 children and young people.

In 2012 around 320 young people in Hillingdon aged 16-18 were thought to be not in education, employment or training (NEET), which represents 3.6% of the population of that age, a lower proportion than in London or England. This proportion has fallen from 5.7% in Hillingdon over the previous 6 years. The largest numbers of the NEET cohort live in Botwell, Townfield, Uxbridge South, West Drayton and Yiewsley, and White British are over-represented in this group. In the 2011 Census 2450 (2.6%) of those aged under 25 in Hillingdon reported that they were unpaid carers, with the highest proportions in Hayes and Harlington and lowest in Ruislip and Northwood. Data provided by the Hillingdon Carers service suggests that there are Young Carers as young as 5 in Hillingdon. 253 school children living in Hillingdon were identified as Traveller children in the 2013 school census, 47% of whom were identified as having some special educational need.

**Child Deaths:** In total there were 151 child deaths in Hillingdon over the 5 years 2008-2014, about 60% of which occur under the age of 1, and just under 20% in older teenagers aged 15-19. Most infant deaths are due to perinatal or congenital causes. The commonest single cause of death in older children is external causes, accidents and injuries, and adolescent boys are particularly at risk.

**Hospital Admissions:** The rate of hospital admissions of young people aged under 18 for alcohol specific conditions (those which are causally related to alcohol) is higher in Hillingdon than the rest of London, and the trend has fallen only slightly in the last few years.

**Teenage Pregnancy:** There has been a significant decline in rates of teenage pregnancy since 2007, which has been even more marked in Hillingdon than in the country as a whole.

**CAMHS:** Over 1000 children aged 2-18 were referred to Tier 3 CAMHS in 2013/14, of whom 55% met the service's referral criteria and were seen. The number of referrals increases with age and there appear to be more White British children seen in the service than would be expected from the ethnicity profile of children and young people in Hillingdon. Almost one-quarter of those seen had hyperkinetic disorders, 12% had other behavioural and emotional disorders, and 11% other anxiety disorders. Estimates based on national data suggest that the numbers who used CAMHS services in Hillingdon are about half that expected for Tier 2 and Tier 3 services, and about two-thirds that expected for Tier 4. In 2012-13, 112 young people aged 10-24 in Hillingdon were admitted to hospital as a result of self-harm. This rate has remained stable over the last 5 years and is significantly lower than the England average. However the number of young people referred to CAMHS from Hillingdon A&E due to deliberate self-harm has increased more than 2.5-fold between 2008/9 and 2013/14, but it is not clear whether this discrepancy between referrals and admissions is due to changes in recording or referral practice, in the population of young people involved, or to increases in the rates of self-harm. However it is clear that there are currently significant numbers of young people who self-harm and this is a concern. Some groups such as young South Asian women are known to be at increased risk.

**A&E Attendance:** Almost half of all 1-18 year olds attending A&E were children aged 1-5, and among these younger children injury and poisoning are the commonest reasons for attendance, followed by respiratory conditions.

**Educational Outcomes:** Data on educational outcomes shows that levels of development at the end of reception year are lower for Hillingdon than in Outer London or England. However at Key Stage 1 and Key Stage 2 overall achievement in Hillingdon is better than that for England and in most areas similar to or slightly better than that for Outer London. At Key Stage 4 overall achievement is still better than England in most areas but has fallen below that of Outer London. The exception is for White pupils who fare worse than the England average, and this is particularly marked for White boys in Hillingdon.

### **Commentary.**

Although, by and large, Hillingdon offers young people a good place to grow up there are some particular concerns. There is a danger that the overall affluence of the Borough can mask the difficulties for some. That 25% of children aged 0-15 live in poverty with up to 40% in some wards is a particular concern given what we know about the potential outcomes for these children.

There also appear to be higher rates of hospital admission for self-harm and alcohol related incidents amongst children and young people than we would

expect. This is particularly concerning when linked with lower than average referral acceptances by CAMHS. This will be of particular scrutiny during the forthcoming year.

Although children missing education are lower than some other areas, the LSCB plans to obtain more information about these, and children educated at home as potentially vulnerable groups.

### 3 WHAT WE HAVE DONE

#### What we planned to do – our key priorities

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

The five priority areas of work are detailed below, with a summary of work completed against those priorities during 2013-14.

During the year the capacity of the LSCB to carry out some of its tasks were compromised by the absence of a dedicated Business and Development Manager. Time allocated to the Board had historically been used for direct training delivery but in future training will be commissioned externally, thus releasing time for dedicated business management. Maintenance of good practice continued in areas such as multi agency work on missing, trafficked and exploited children, but little time was available for LSCB development activity. This was reflected in the Ofsted findings and has been addressed for 2014.

What we planned to do at beginning of 2013-14	What we did
<b>Priority 1 Improve LSCB functioning</b>	
Implement Munro recommendations and Government guidance as required	<p>"Working Together 2013" was adopted and built into multi agency training</p> <p>Revised London procedures were adopted Jan 2014</p> <p>Early Help assessment developed, agreed and implemented</p> <p>Signs of Safety adopted and plan developed. Revised plan produced following Ofsted inspection and full roll out took place July 2014. Positive early feedback from professionals and families</p>
Find ways of assessing LSCB effectiveness	Independent review of LSCB carried out, alongside Ofsted inspection. Findings incorporated into implementation plan
Incorporate views of children and their families and staff into the work of the Board	Very small survey carried out among young people going off CP plans. Changes in conference processes

	adopted in response
Improve ways in which LSCB communicates with professionals and the public	Online survey carried out among staff summer 2013 Responses incorporated into business plan
Raise awareness of abuse linked to faith or belief	Safeguarding training delivered to 70 staff and volunteers in 6 mosques and madrassahs Specialist DV Health Visitor undertook training with faith groups.
Continue to improve data available to the LSCB	Further improvements still required to LSCB data set. Carried forward to 2014 and picked up by the Performance and Quality Assurance sub-group
Improve engagement with GPs as providers	Named GP appointed in spring 2014. One session per week for children Relevant safeguarding issues incorporated in GP training programmes and successful master class held at GP Forum Audit tool on safeguarding practice sent to all GPs. Poor response but increase in requests for level 3 training and bookings from GPs
Improve governance links between LSCB and Health agencies, and with other Boards	CCG well represented on Board Annual Report presented to Health and Wellbeing Board and development of protocol agreed. Signed off at LSCB June 2014, HWBB July 2014 Annual report presented to Community safety Partnership
Maintain and develop links with schools as they become more independent of the local authority	Head teacher groups represented on LSCB Third safeguarding cluster set up



<b>Priority 2 Assess and improve operational practice</b>	
Ensure all agencies fully understand social care threshold criteria	<p>London Board levels of need adopted</p> <p>Revised Threshold criteria and assessment protocols developed and agreed by LSCB March 2014. To be tested in practice</p> <p>Case review used as practice example in development of early intervention service</p>
Develop single holistic assessment process in line with Government guidance	Developed and launched in November 2013.
Develop a quality audit programme for LSCB multi agency learning	<p>Small number of cases audited by Risk panel and reported.</p> <p>Quality audit programme agreed for 2014</p>
Carry out audits and report on single agency audits	<p>Single agency audits reported June 2014 and included in annual report</p> <p>Schools audit carried out and reported</p>
Establish system for responding to 'stuck' and concerning cases	Included in terms of reference for Risk Panel, but this needs to be further reviewed as part of Improvement Plan
<b>Priority 3 Improve outcomes for children affected by key risk issues</b>	
Continue to maintain and improve operational practice in respect of young people potentially at risk of trafficking	<p>Maintained though operational group. Hillingdon has been quoted in DfE guidance on missing children/trafficking</p> <p>Commended by Children's Commissioner following visit May 2013 and August 2013. This in response to representation about planned Home Office changes to assessment of unaccompanied asylum seekers</p>

<p>Improve identification and support for those at risk from sexual exploitation</p> <p>Improve identification and support for missing children and runaways</p> <p>Improve practice in respect of those at risk of gang activity</p>	<p>All included in strategic and operational groups</p> <p>Terms of reference of operational group updated to include recommendations from national strategy re sexual exploitation</p> <p>Schools officers have completed training on gangs and are delivering to secondary schools</p> <p>Some young people identified as at risk. Good local multi agency practice supported those young people and joint investigations have led to legal action. This extensive operation continues into 2014</p>
<p>Review services for children who experience domestic violence and suggest improvements</p>	<p>Review carried forward. Services for families affected by domestic violence assessed positively in the Ofsted inspection of November 2013, "MARAC are well established....inspectors saw evidence of appropriate communication between police and children's social care through MARAC and this is helping to protect children".</p>
<p>Increase awareness among young people and parents of e-safety issues and what to do</p>	<p>Cyber mentor scheme up and running in schools. Newsletter for schools includes relevant information about CEOP APP</p>
<p>Monitor compliance with private fostering procedures</p>	<p>LSCB has received regular reports through the year on private fostering. Procedures complied with in respect of notifications made, but notification numbers are still low. Short life task group agreed at LSCB to report Sept 2014</p>
<p>Improvements for children living with adult mental illness/substance misuse</p>	<p>Joint protocol across adult and children's services agreed</p> <p>Reciprocal surgery arrangements in place across children's social care and adult services/drug and alcohol services</p>

<b>Priority 4 Ensure a safe workforce</b>	
Provide support and training for universal services	Promoted through e-learning module e- learning module on safer recruitment rolled out
Develop ways of assessing access to and impact of training	Pilot training tool used and recommendations brought to LSCB June 2014
LSCB to improve oversight of multi agency training	Half year report to LSCB who agreed content of multi agency training programme 2014-15
Continue to improve response to allegations against staff	Government guidance disseminated to schools
Implement Signs of Safety across Partner agencies	Training and briefings carried out across partner agencies  Updated implementation plan developed early 2014 and roll out took place July 2014
Enhance support to front line managers	Each agency has developed this as appropriate
Ensure safer recruitment	New guidance developed and agreed on DBS checks and protection of freedoms Act  Safer recruitment guidance updated
<b>Priority 5 Learn from Case Reviews</b>	
Continue to raise awareness of practice issues arising from unexpected child deaths and serious case reviews	The Panel is jointly funded by Hillingdon and Ealing and works across both boroughs
Disseminate learning from SCR and other case reviews to all staff	Sessions delivered for staff on key national SCRs

## 4 GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

### Operation

The LSCB operated during 2013-14 in accordance with Working Together to Safeguard Children 2013.

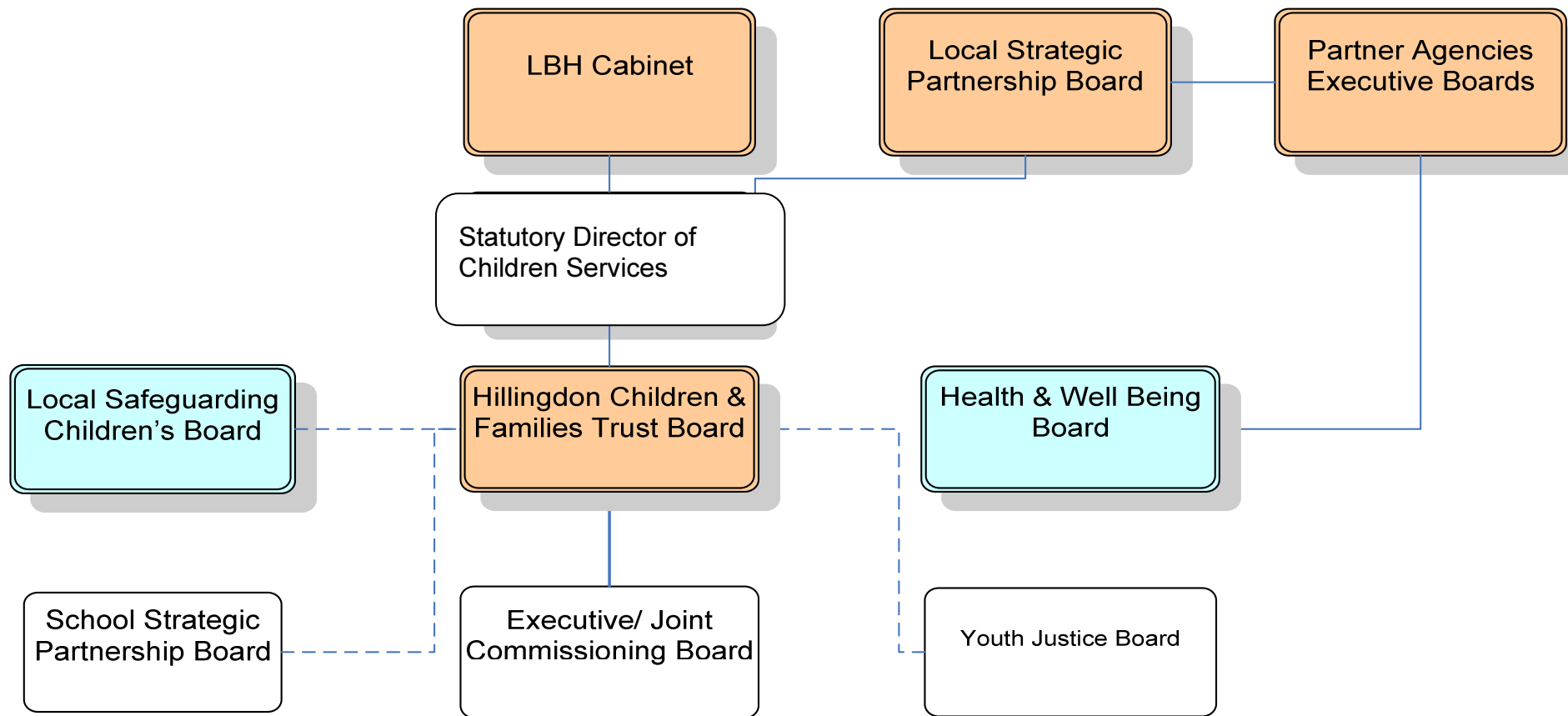
There were 11 sub groups of the LSCB who met between Board meetings and took responsibility for actions identified in the Business Plan. The Domestic Violence Forum is a Council led body that sits outside the LSCB governance structure, so joint work is taken forward through the Community Engagement sub group. Following review the LSCB has reduced the number of sub-groups to four, with some additional “task and finish” groups for the year 2014/5.

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

Although there is no longer a statutory requirement to have a Children’s Trust, the Hillingdon Children and Families Trust Board (HCFTB) continues to meet in order to oversee the Children and Families Plan. The LSCB chairman sits on the HCFTB and through 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.

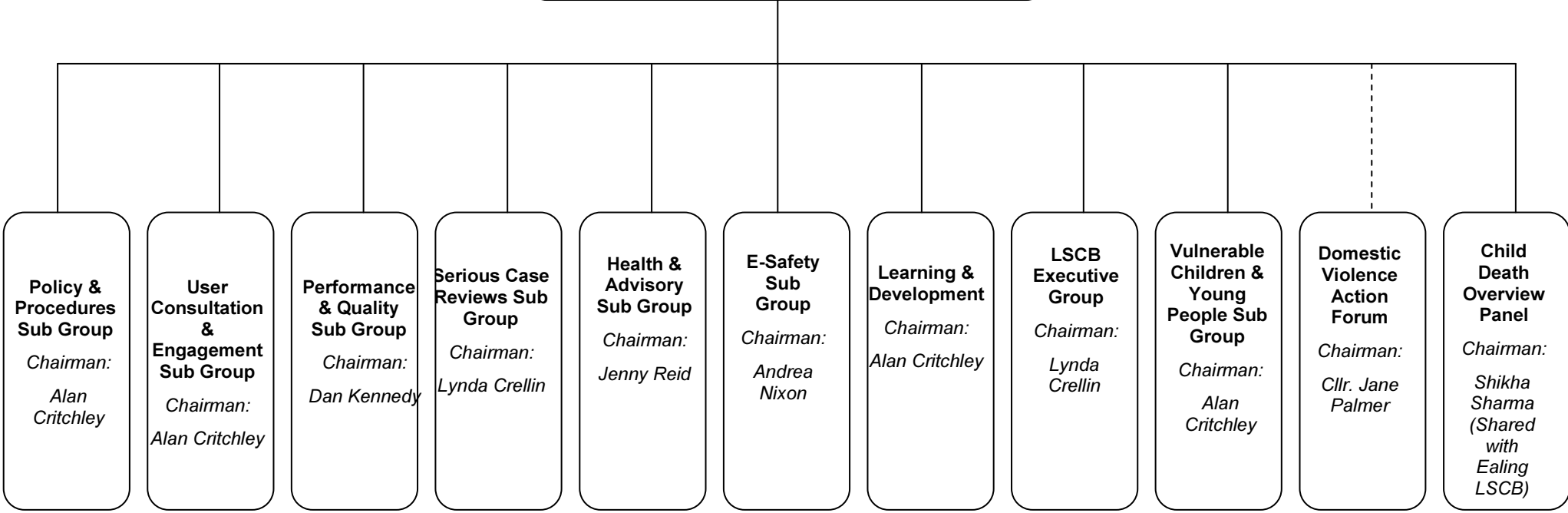
This annual report will be presented to Council Scrutiny Committee, to Cabinet, to the Health and Wellbeing Board and to the Community Safety Partnership. It will feed into the Local Strategic Partnership Board (LSP) through the HCFTB.

Closer links had been made with the Safer Adults Partnership Board (SAPB) and the potential identified for some joint work including a scrutiny of domestic violence arrangements, and the development of preventative services for families. A new Adult and Children Safeguarding sub-group set up in 2014 will take forward the cross-over working.



# THE STRUCTURE OF HILLINGDON'S LOCAL SAFEGUARDING CHILDREN BOARD

**Hillingdon LSCB**  
Independent Chairman:



## **Membership**

The LSCB is a large, inclusive and generally well attended Board, supported by strong sub groups. Overall attendance during 2013-2014 was 75%, with CAIT, schools, Local Authority, CCG, Hillingdon Hospital Trust, Hillingdon Community Health and Public Health showing 100% attendance. Probation and Borough Police showed a lower attendance of 25%. Cafcass were unable to send a representative. 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. We are currently in negotiation with NHS England (London region) about their representation. Full membership 2013-2014 is attached as appendix 1.

## **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 Chief Executive of the Council. The chairman meets regularly with the Chief Executive, Director of Children's Services, Cabinet 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.

## **Hillingdon Council**

### **Social Care**

The Council was represented on the LSCB by the Director of Children's Services. 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 Cabinet 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, Young People and Learning Policy Overview Committee reviews key safeguarding areas – the most recent of these being children missing from care and social care audit report. Recommendations are incorporated as appropriate in the LSCB work plan. This annual report will be presented to Policy Overview Committee and Cabinet.

### **Internal Governance arrangements**

The statutory Director of Children's Services has maintained oversight of key services relating to safeguarding children, via a monthly meeting with the Cabinet Member for Education and 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, Cabinet Member and Director of Children's Services to have scrutiny of child protection activity on the ground.

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

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

One of the key issues for improving and strengthening child protection practice is the quality of management oversight and supervision provided to front line social workers.

## Schools

### **Schools audit April 2013-April 2014**

The schools safeguarding audit was distributed to all schools in April 2013 for completion by April 2014.

The return from schools was poor initially but after prompting through the Primary forum and the Hillingdon Association of Secondary Heads (HASH) the return was increased slightly but to only 41%.

There were no concerns raised through the audits received and schools felt that the process was useful and the audit helped inform the annual report for their Governing body.

The safeguarding audit has been revised for 2015 to incorporate the recommendations from the recent publication, 'Keeping Children safe in Education'. This will be presented at the Primary, Secondary and Governor forum prior to circulation in 2015 to allow the schools time to incorporate it in their work plan.

A Serious Case Review has been commissioned in 2014 which will further inform our work with schools

## Early Intervention Services

### **Strategic achievements secured in 2013 - 2014**

- Work has continued across the partnership to meet the operational objectives of the early intervention and prevention strategy.
- The development of a service delivery framework for early intervention that enables existing services to be mapped against and organised within the continuum of need.
- The development, introduction and application of Early Help principles and processes including the Early Help assessment and the application



of the Team around the Family process. We have seen increased application of these processes across the partnership. As a consequence more families are benefiting from effectively coordinated Early Help;

- The establishment of the Family Centred Network South and the initiation of the Family Centred Network North. A Family Centre Network is a partnership group of service providers working together to deliver a coordinated programme of services that respond to the support and development needs of families, children, and young people in a local area. This involves supporting families, children, young people, and communities to manage commonly-occurring risks through preventative inputs, so family members can progress towards positive outcomes. The model is proving successful in the south of the Borough with over 40 organisations mobilised and is now being replicated in the north.

## **Achievements of the Council's Early Intervention Services in 2013/4**

### **Children's Centre and Early Years Services**

- The successful introduction of a new locality-based model of practice for Children's Centres which has seen localities collaborate and jointly commission services in response to locally identified need;
- The introduction of 'five to thrive', an evidence based prevention programme that supports children's brain development and parent: child relationships through parents adopting 5 key behaviours: Respond, Cuddle, Relax, Play and Talk;
- Increased take up of Children's Centre services by targeted / vulnerable families – 80,822 places filled by targeted groups (67,353 in 2012/13).
- Increase in new family registrations with Children's Centres 6,407 (2,947 targeted families) up from 3,964 (2,083 targeted families) in 2012/3.
- Increased take up of funded places for vulnerable 2 year olds from 37% in September 2013 to 70% in June 2014.

### **Youth Work and Youth Support Services**

- The introduction and expansion of 'I-Choose' and 'Unique Swagga' programmes which provide informal learning opportunities for vulnerable boys and young men and girls and young women. Outcomes for the 270 participants thus include confidence and self-esteem development and risk avoidance and management techniques;
- The establishment of Mosaic, a partnership project to meet the needs of lesbian, gay, bi-sexual and trans-sexual young people;

- Supporting 440 young people with emotional and psychological difficulties through the provision of 1 to 1 counselling by Link Counselling Services;
- Addressing substance misuse amongst young people through the provision of counselling and signposting, informal education information and advice sessions for over 1,000 young people;
- Supporting over 1,000 young people to avoid risky sexual activity and to develop positive relationships through the provision of KISS sexual health services;
- The delivery of the CLEAR programme, a sexual health and peer education programme targeted at 16+ students in London Borough of Hillingdon and the training of 16 peer educators; and
- The introduction of adolescent substance misuse awareness training for parents. 32 parents of teenagers have received parenting support from 'Sorted' substance misuse services. This includes group work at Northwood Young People's Centre and support for foster carers. Sorted have also provided one to one support, information and advice by telephone and to parents who have asked for additional information after the group work sessions.

#### **Family Information Services**

- The development of the Family Information Service on-line directory;
- Targeted outreach work to support and encourage take up of the 2 year old offer of childcare to vulnerable families; and
- Expanded use of social media to communicate with families.

#### **Education Welfare**

- The service has carried out successful joint work with the Local Area Designated Officer (LADO) to challenge 3 independent education provisions that had established themselves in Hillingdon without regulation.
- The service has been commended by the Day Chairman of the Bench at Uxbridge Magistrates Court for the detailed and strenuous efforts to engage hard to reach families and secure their children's access to education.

#### **Elective Home Education (EHE)**

- The Service continues to work with the School Improvement Service and partners to meet the needs of parents and children who elect to educate at home.
- Operational responsibility for EHE lies with the Education Welfare Service. Numbers of Hillingdon EHE children have increased by 110% since 2012. As of 29<sup>th</sup> May 2014, the known figure stands at 202. Approximately 65% of these children are believed to be vulnerable in terms of family ability to deliver an acceptable standard of education.
- The service has introduced a 'RAG' rating system in order to identify and monitor risk so that interventions may be made if necessary.

- Local increase in EHE levels is reflected nationally and Hillingdon has been invited to represent London at national LA EHE organisation being created through the Education Select Committee under Graham Stuart M.P.

### **Children Missing Education**

- The Education Welfare Service continues to work with schools and relevant partner agencies to enable and ensure that children access their education entitlement. Children missing education numbers have increased by c.17% since the 2012-13 Hillingdon LSCB annual report.
- Since November 2013, Ofsted has required the Local Authority to be informed of all pupils in receipt of part time provision. This information is requested, recorded, tracked and updated by the Education Welfare Service on a 3 weekly cycle with multi-agency input to support the pupil back to full time provision.
- As of 29<sup>th</sup> May 2014, there were 292 children resident in Hillingdon known to be without a school place. The percentage breakdown in terms of year groups is as follows:

Reception 7%	Yr 7 12.38%
Yr 1 10%	Yr 8 5.71%
Yr2 11.43%	Yr 9 8.57%
Yr 3 7.62%	Yr 10 4.29%
Yr 4 10%	Yr 11 9.52%
Yr 5 6.66%	
Yr 6 6.66%	

- The total number of statutory school aged pupils in Hillingdon permanently excluded from school is 21 during academic year 2013-14. Trends indicate an increase in permanent exclusions, a continued disproportionately high number of white (UK) boys entitled to free school meals, violent reasons increasing, weapons decreasing to date. The Service continues to work with partners, within the context of the early intervention and prevention strategy, to keep the number of children and young people not attending school to the absolute minimum.

### **The Troubled Families programme**

- The Troubled Families programme in Hillingdon has delivered positive outcomes with 43% of all 555 families identified as meeting the required entry criteria using the Education Welfare Service and Youth Offending resource and a DWP secondee.
- The programme has added value to work being undertaken with vulnerable families by supporting and promoting a holistic approach to problem resolution.

### **The Family Key-Working Service**

- The model of practice developed for this service was positively regarded in terms of its support for vulnerable families by Ofsted inspectors;
- The alignment of the Early Intervention Key Working Team to the Early Help assessment process and model so that vulnerable families who need additional support receive it;
- The 'Team around the Family' (TAF) coordinator role has successfully supported the application of the TAF process in a wide range of settings and has advised partner agencies to the point at which the process is being applied independently and as a matter of course in increasing numbers.

### **Youth Offending Service**

- A review, with partners of multi-agency work with children and young people who exhibit sexually harmful behaviour, against the good practice and recommendations contained within the HMIP Inspection report published in February 2013. The findings were presented to the LSCB and an action plan agreed, but this is dependent on the availability of specialist CAMHS time
- The implementation of the new pre-court disposals system which promotes the diversions of young people from the formal court system where at all possible. In 2013/14 the number of first time entrants into the criminal justice system continued to fall with 102 recorded in 2013/14 compared to 146 in 2012/13.
- Using intelligence obtained from young offenders and local research, practitioners mapped a network of associations identifying those young people likely to be or at risk of becoming involved in gang/serious youth violence. This work was shared with partners and the proposal of a local strategy based on this research is currently being made through the Safer Hillingdon Partnership processes.
- Intelligence from young people regarding links between drug distribution networks and the possible sexual exploitation of young people was shared with partners and resulted in a police operation following which a number of arrests have been made and vulnerable young people provided with support.
- 34.6% of young people sentenced between April 2011 and March 2012 committed further offences in contrast to 37.5% in the previous year. This is lower than for the London region (39.3%) and England (35.4%).

### **Developments for Early Intervention Services in 2014/5**

- Work continues to develop and implement Early Intervention and Prevention Strategy. Work is currently being progressed to review the outcomes it is seeking to effect and to formulate early intervention priorities 2014 - 2017 as part of the process of renewing the Children and Families Trust Plan.

- As previously referenced, Early Intervention Services have been testing new ways of working within the context of the Children's Pathway programme. As part of the process the service is subject to an ongoing review of early support services. The review has been completed with work now underway to act upon the outcomes and associated recommendations. Key developments include the Borough-wide roll-out of the family centred network initiative and full alignment of early support services with social work teams.
- Within the context of developing new ways of working the Education Welfare Service is introducing a monthly electronic return from September 2014 that will capture all persistent non-attenders, children removed from roll (for all reasons) and children on part time programmes. This will enable regular tracking to ensure all children are in receipt of their full time educational entitlement and to meet schools and local authority OFSTED & statutory obligations. The e-return applies to all maintained schools, academies and free schools in Hillingdon.
- Work continues to embed the Early Help Assessment and Team around the Family processes throughout the children's economy.
- The Youth Offending Service is developing and implementing a custody improvement plan based on analysis of custodial sentences imposed on Hillingdon young people.

## Children with disabilities

During the year a restructure meant that the Children with Disability team moved to an all-age disability service. Whilst this does concentrate the expertise the LSCB have some concern that the clear focus on the child has the potential be diluted.

The number of children with a disability subject to child protection procedures is low, in the year there were 24 referrals of concerns with three children becoming subject to procedures, one of them being subject to Care proceedings. This will be the focus of further enquiries from the LSCB in the forthcoming year.

A case review was carried out in 2013-14 and actions following from this review have been completed. However, the issues relating to listening to the voice of children and young people and the quality of safeguarding within families remain areas that the LSCB wishes to monitor as the All Age Disability Service is developed.

## Voluntary Sector

The voluntary sector in Hillingdon is made up of around 100 independent organisations working with children, young people and/or families. They range from branches of large national charities to small local groups which may provide services to just a handful of children. Approximately 75% are volunteer led with no paid staff. 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.

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.

The Hillingdon Association of Voluntary services (HAVS) has provided level 1 safeguarding training for voluntary groups in Hillingdon. HAVS also offer support to groups on developing their safeguarding policy and advice on referrals.

Last year the HAVS safeguarding officer was approached by a local Mosque to provide child protection training to members of the Mosque. This was gratefully received and hopefully these links can be maintained. Unfortunately the safeguarding advisor for HAVS has now left and this post has not been filled. Groups are encouraged to use the on line level 1 safeguarding training provided by the LSCB.

The LSCB is aware the excellent work undertaken by the voluntary sector and the funding constraints within which they operate. The loss of the Safeguarding Coordinator role is of concern and the LSCB will work with HAVS to ensure that safeguarding remains a priority in the voluntary sector.

## Health Agencies

### **Clinical Commissioning Group**

The NHS Hillingdon Clinical Commissioning Group (CCG) is the PCT successor organisation and like the PCT has responsibility for Safeguarding Children.

The Chief Operating Officer (COO) is the Executive Lead for Safeguarding (Children and Adults) and sits on the LSCB along with the designated nurse and doctor; CCG Governing Body GP safeguarding lead and senior representatives from all of the main Provider Organisations.

The designated nurse and doctor report directly to the COO and are a source of advice and support to health service staff. They oversee safeguarding practice across the health economy.

The designated professionals provide safeguarding children supervision to the named professionals and key staff in the provider organisations on a regular basis.

As well as designated professionals for Safeguarding Children and in accordance with 'Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (2013)', the CCG has secured the expertise of a designated doctor and nurse for looked after children and a designated paediatrician for unexpected deaths in childhood. A named GP has been employed as a resource for Primary Care.

The designated and named professionals and other key senior staff play an active part in the work of the LSCB through its sub groups.

Each Provider organisation has its own safeguarding children committee with feedback to and from the Health Advisory Group and the CCG quality assurance arrangements.

The CCG takes its safeguarding children responsibility seriously and will ensure that safeguarding children remains a priority.

### **Central and North West London Health NHS Foundation Trust Mental Health and Community Services**

#### **Governance and Accountability**

##### **Internal Governance**

The Board of Directors received regular updates on safeguarding children issues and serious incidents are reported to the Board under Part II by the Corporate Governance Lead. The Board also had an annual training presentation on safeguarding children. The presentation focussed on community health services including resources for safeguarding children in the community and services for looked after children. As these services deal with vulnerable families on a daily basis, safeguarding is a core component of the services.

Since April 2013, the quarterly Trust Wide Safeguarding Group, a sub-committee of the Board, has been chaired by the Director of Nursing and

Operations. Membership consisted of the Trust Named Doctor and Nurses, Director of Operations and Partnerships, Associate Director of Operations, key leads from community and addictions. In addition, appropriate leads, for example, from Human Resources, are in attendance.

The Hillingdon Safeguarding Group provides a written report to the quarterly Safeguarding Group. The report summarises all the key issues in relation to safeguarding children across Hillingdon 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 the Named Nurses in CNWL and Hillingdon and information regarding local processes are fed into the quarterly Safeguarding Group to provide on-going continuity.

The Monitor Declaration was reviewed and updated to include all services provided by the Trust. This is on the public web site in accordance with Monitor requirements and will be revised annually.

### **External Governance**

The Trust also takes a full and active role in working with LSCBs where the Trust provides services. Maria O'Brien, Divisional Director of Operations provides representation on Hillingdon's LSCB and acts as Deputy Chair.

Each LSCB has a variety of sub groups and representatives from the Trust attend those relating to quality assurance, training and development and serious case reviews. The Safeguarding Children Team reviewed the sub groups for all of the LSCB's in 2013 to ensure appropriate representation and feedback over issues.

Feedback from LSCB meetings is given to relevant Service Lines/Directors, and disseminated through Borough Interface Meetings and the relevant Care Quality and Performance Groups, as well as Trust Safeguarding Group Meetings.

The Trust has had regular representation at external groups reviewing risk like Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC).

### **Main achievements:**

The Safeguarding Children annual work plan has key action areas for 2013/14 as well as issues which emerged during the year:

***Update the Safeguarding Children Policy***-The CNWL Safeguarding Children and Young People policy and the Escalation guidelines were revised to reflect the services outside London, changes from Working Together (2013) and the review of the London Child Protection Procedures.

***Coordinate Audit Plan***, particularly now most LSCBs are undertaking multi-agency audits as well as Section 11 Audits, which will be updated for 2013/14. Hillingdon safeguarding children team completed an audit of child protection records focusing on the child's views. Continued support will be offered in order to help staff develop their skills in this area.



**Agree changes in accordance with DBS Guidance-** changes in accordance with DBS Guidance Safer recruitment principles are included in the Trust recruitment policies and procedures and training incorporates this. However, in 2013 the NHS Employers Recruitment Checklist was revised to take into account changes to the DBS and the Trust is fully compliant with this. Training in safer recruitment is incorporated into recruitment and selection training. The Trust's senior officer for managing allegations against staff continues to be the Named Nurse, Paul Byrne.

**Regular meetings for Named Nurses within CNWL.** There are now quarterly Named Nurse meetings in place for all of the different services in the Trust. This group has allowed for some peer group supervision as well as helping to develop integrated working across all services provided by the Trust. The Named Nurses also provide cover for each other and provide specialist advice for all staff in CNWL. Integration has provided more resource to cover the increasing demand for safeguarding advice, support, and supervision.

**Maintain training levels above the target including an increase delivery of training on Safeguarding Children to Medical staff in MH&AS.** The training level for both community (including sexual health) and mental health staff has exceeded the target. Mandatory training now includes safeguarding children in accordance with the Skills for Health Framework and this is reviewed in supervision and annually at appraisal. Training figures are assisted by all staff receiving Level 2 at Induction, before they start work.

The safeguarding children named staff have devised a combination of e-learning and face to face training to support the Trust meeting the mandatory target and this will be reviewed next year with the development of training on domestic violence, a key risk factor in safeguarding children.

Single Agency CP Training in Hillingdon Community:

Level 1 and 2 training is delivered directly to staff as a face to face session. Refresher courses are provided via e learning. Compliance rates are good, Level 1 100%, Level 2 99% and Level 3 Working Together Multi Agency 94% of target group<sup>1</sup>

Staff have received training in preparation for the implementation of the Signs of Safety, new approach to child protection conferences.

**Checking compliance with Working Together (2013).** CNWL have ensured the workforce are aware of the key changes contained in the revised statutory guidance *Working Together to Safeguard Children* (2013).

**Contribute to development of Multi Agency Safeguarding Hub (MASH).** On occasions, the Health Visitor linked to the MASH will contact mental health or addiction services where there is a concern about the safety and welfare of a child and under these circumstances, information is shared, supported by Information Sharing Agreements signed by the Trust. The Named Nurse in

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<sup>1</sup> Potential core group members

Hillingdon provides support and supervision to the nominated health professional allocated to the Hillingdon MASH.

***Support development of a Think Family approach across all services.***

The “Think Family” approach has been adopted into the Care Programme Approach and our risk assessment and management procedures. These processes embed the identification of children and have been commended by the CQC. However, we are not complacent and safeguarding children training incorporates this as a key theme. The integration of community services has supported the implementation of this agenda and for this understanding to become more robust.

***Review demand and pursue appropriate solutions in relation to Tier 4 provision.*** Over 2013/14, the Trust continued to experience difficulties in finding appropriate placements for adolescents in need of admission to in-patient mental health services. This is a national problem and has been exacerbated by changes in commissioning arrangements and reductions in provision in non-health sector organisations such as local authorities and education. This has resulted in a number of young people waiting in A&E departments for extended periods of time whilst a bed is allocated. As there was, and is, a national shortage of specialist beds on occasions the Trust had to admit an under 18 year old to an adult ward.

CAMHS explored the possibility of developing a Tier 4 adolescent unit within CNWL and a project group reviewed the feasibility of this. A report was devised which detailed the proposal and this could not be progressed as NHSE were unwilling to commission new services whilst the national review of Tier 4 was being undertaken. The National Review is due to publish in summer 2014 and CNWL contributed in a variety of ways including a written submission.

The Trust continues to highlight the issue to LSCBs and to Specialised Commissioning as there are clear impacts of distant admissions for children and their families. There is a particularly gap of admission facilities for adolescents with learning difficulties and complex mental health needs.

### **Emerging Issues**

There were several emerging issues over the year relevant to safeguarding children:

- Learning from the revised inspection regime of the CQC, which is questioning partnership arrangements
- Learning from the revised inspection regime of Ofsted, which now reviews the effectiveness of the LSCB in their inspections
- Domestic Violence Guidance now covers young people from 16 upwards and an increasing recognition of the toxic trio (mental health, substance misuse and domestic violence) are found in the majority of Serious Case /Learning Lessons Reviews
- Child Sexual Exploitation, particularly regarding gangs and the grooming of vulnerable young girls and the establishment of Multi-Agency Child Exploitation (MACE) Panels, ensuring appropriate links with

Contraceptive and Sexual Health services. The Hillingdon Safeguarding Children Team has and will continue to work in partnership with the local authority in order to identify and safeguard children at risk of sexual exploitation. Training has been offered to key staff groups to ensure Hillingdon staff are aware of how potential or actual victims may present and what the local arrangements are.

- Increasing awareness and reporting of harmful cultural practices, for example, Female Genital Mutilation (FGM), and child abuse linked to spirit possession and witchcraft
- Change in commissioning arrangements for CAMHS, Addictions, Health Visitors and School Nursing and the Local Authority guidance need to complete a procurement exercise every 3 years
- Low numbers of referrals of private fostering (when a child under 16 is cared for by someone who is not their parent or close relative for longer than 28 days)
- Signs of Safety – part of the strengthening families model – is changing the way that case conferences operate and increasing the voice of the parents and children

#### **Main challenges/developments:**

Looking to the future, 2014/15, the unprecedented financial challenges in the public sector will require creative solutions and strong partnership arrangements to maintain the high quality of safeguarding practice in the trust. Safeguarding Children training continues to be a high priority for CNWL although freeing up time for staff to attend remains problematic across the organisation.

#### **The Hillingdon Hospitals NHS Foundation Trust**

Safeguarding children arrangements at the hospitals have continued to strengthen during 2013/14. The Executive Director for Safeguarding, who sits on the hospital Trust Board oversees the annual work and audit programmes for safeguarding children and progress against these is now reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2013. The hospitals are well represented on the LSCB and its sub-groups by the hospitals named professionals for safeguarding and senior management staff.

The Trust has a multi agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work, which is chaired by the Executive Director of the Patient Experience and Nursing. Audits in relation to child safeguarding are presented at the committee with associated action plans. Within the Activity data report presented at each committee, safeguarding children incident reports are analysed.

In terms of maternity, the number of enquiries and activity has increased both from within the Maternity Unit and partner agencies in maternity. There has been a rising level of case conference invitations within Maternity and an improved commitment and attendance. Following a review of how this was

previously managed and looking at opportunities to allow staff to be released to attend. This is an ongoing challenge due to clinical work pressures of both the community and antenatal clinic staff.

There are continuing efforts in recruiting more paediatric nurses to the paediatric Accident and Emergency (A&E) department. A Senior Nurse has now been appointed to manage the paediatric A and E department. This is currently on the Trust Risk Register with regard to actions that are being taken forward to mitigate any risk, to ensure that the paediatric nursing team is fully recruited, which is reviewed at the Medical Division governance meeting and Trust Safeguarding Committee.

There is a Urgent Care Centre (UCC), a newly re-commissioned service, adjacent to the A and E department at THHFT. The UCC opened in October 2013. The UCC is led by the Ealing Hospital NHS Trust in conjunction with Greenbrook Healthcare. Monthly Clinical governance meetings have been established, to ensure that staff follow pathways of care and to have effective communication. The Paediatric Liaison Health Visitor liaises closely with the UCC as required.

The Trust training records system has been replaced by a system called WIRED, which is said to improve the accuracy of recording staff compliance, which also links into the Electronic Staff record (ESR). There remains a challenge in order to reach 80% compliance with safeguarding children training, particularly in light of revised intercollegiate guidance and the need for more staff to undertake further training. Overall training compliance has seen an increase within the reporting period.

Safeguarding Children training at levels 1 and 2 training are delivered as part of the Statutory and Mandatory staff training programme and is also part of the monthly New Starters Induction programme to the Trust. Training is also available via e-learning. Bespoke training is also delivered by the Named Nurse to A and E doctors at their induction within the department.

E- Learning at Level 3 is now available for staff to access in addition to face-to-face teaching, to assist with increasing compliance.

There are five dates planned in 2014 for Level 3 training to be delivered in-house. The training is to be provided by a senior safeguarding lecturer at BNU with a Social Work background. This is addition to multi-agency training dates to be provided by the LSCB (usual provider). On-line training at level 3 is also available; it is stipulated, however, that staff should however attend level 3 face-to-face training wherever possible.

The Safeguarding Midwives are providing one-day Level 3 training days for aimed specifically for staff within the division of Women and Children.

A number of staff have attended the Signs of Safety (SoS) training at LBH, in preparation for its implementation.

High quality safeguarding practice continues at the Trust; this is amidst financial savings across all partner agencies.

An annual work programme has been developed to ensure priorities for 2014/15 are closely monitored and that 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.

The Named Doctor at the Trust has now changed, with the addition of an extra Named Doctor. There is also a new Designated Doctor for Unexpected Child Death within the Trust.

## **Metropolitan Police**

### **Child Abuse Investigation Team**

#### **Governance**

Responsibility for ensuring compliance and pan London governance of CAITs sits with the SCO5 Continuous Improvement Team (CIT). The CIT includes quality assurance, training and partnership.

#### **Training**

The MPS has a commitment to continue providing regular training on safeguarding, child protection and effective leadership for managers and practitioners across frontline services. The Specialist Joint Child Abuse Investigation Course (SJCAIC) is a two week training course for new staff members run jointly with social workers. SCO5 also run an induction week for new staff that they attend on their first day of joining the command. The course aim is to provide basic initial understanding of the Child Protection world and partnership working.

The Command has reviewed the Specialist Child Abuse Investigators Development Programme (SCAIDP) in line with the new learning descriptors produced by the NPIA to ensure that all accredited investigators maintain this qualification through evidence based assessments.

SCO5 is currently running an 'Advanced child interview course' for interviewers of very young children and children with learning or communication difficulties. This will deliver a better service to victims and witnesses of abuse and will contribute to wider efforts to enhance community confidence in the police. SCO5 will continue to support the use of intermediaries in relevant cases.

Sudden Unexplained Death in Infancy (SUDI) training is provided for all relevant police personnel and associated professionals. This training includes work with families who have suffered bereavement. SCO5 staff attend and also contribute to LSCB training and promotional events.

#### **Quality Assurance**

SCO5 continues to utilise the Child Risk Assessment Matrix (CRAM) across London to better inform decision-making. This process makes a qualitative assessment of all relevant factors relating to a child and allows appropriate and informed decision-making, and is now more comprehensively recorded on the police crime reporting data base. A thematic review of this system is underway to identify any learning and further enhancements that can be made.

SCO5 has reviewed its response to victim care in line with the Commissioners Total Victim Care ethos to ensure that victims or a suitable point of contact are being updated regularly. Performance in this area is subject of monthly SLT review and weekly team inspections. It is recognised that the command can continue to improve in this area.

SCO5 works closely with local boroughs on community (including youth) engagement. SCO5 also has a dedicated partnership team, which leads on developing engagement with the communities we serve. The partnership team undertake a number of strands of work around key areas to enhance engagement and encourage community confidence. Examples include engaging with other professionals such as, LSCBs, Health, Education, Probation and LADOs to promote child protection procedures and provide safeguarding awareness. Pro-active events around FGM have been well received. The use of SPOCs on each CAIT to offer support and guidance in relation FGM is ongoing and will ultimately promote the use of Non Government Organisations to engage with children and families.

The SCO5 SLT has recently introduced a daily 'Grip and Pace' meeting which reviews all overnight issues including SUDIs and children on a CP plan being victims of new allegations. This ensures that enhanced protection for children subject to a child protection plan is reviewed by SLT, actions identified and prioritised. NVOC are recorded centrally by the Continuous Improvement team.

SCO5's relationship with MASH is being reviewed under the direction of an Senior Leadership Team lead. SCO5 have invested significant resources into ensuring efficient and effective information sharing practices through the development of new risk based approaches and enhanced referral desk capacity. SCO5 have collated information that shows these new practices have identified victims and allowed for safeguarding interventions which may have been missed previously. All SCO5 training, but in particular the multi-agency training, focuses on minimising the risk to children through appropriate information sharing and empowering staff to use and develop their professional judgement. SCO5 have also recognised that this needs to be supported by strong supervision. SCO5 has changed its structure to ensure sergeants, in particular, are able to offer support and guidance to staff managing cases. These workloads are reviewed annually to ensure an appropriate distribution of resources.

### **Hillingdon Borough Police**

This annual report highlights some of the work and multi-agency involvement in Safeguarding Adults/Children involving Hillingdon Police from several of the departments within the Criminal Investigation Department of the Metropolitan Police based within Hillingdon Borough.

A large resource intensive part of this work is the **Missing Person's Unit's** investigations to locate, return and debrief missing children.

During the period 1st April 2013 - 31st March 2014 there were a total of **736** missing Children under the age of 18.(14 less than the previous year) The breakdown of some of these statistics is that 55 were High Risk, (31 more

than previous year). 681 were Medium Risk (23 more than the previous year and 0 recorded Standard Risk (68 less than the previous year).

There is a caveat that several of these Missing Children go missing on multiple occasions and often more than once in the same day. These recidivists are subject to scrutiny and intervention plans when discussed at Missing Children Operational Meeting

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

The MASH awaits a final go live date and the arrival of all the other partner agencies except Hillingdon Children's Service who work together with Hillingdon Police in partnership on this project.

## **Multi-agency public protection arrangements (MAPPA) in Hillingdon**

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

Category 1: All registered sex offenders.

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

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

This year has been another busy year for Hillingdon with up to 121 referrals received per month, under the three categories above. The cases are managed at 3 levels:

Level 1: Single agency management;

Level 2: Active multi-agency management;

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

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

From January 2013, all referring agencies to MAPPA – police, probation, mental health services and youth offending service screen their own cases

and decide what risk level they will assign as the lead agency holding the case. This new way of working across London has brought Hillingdon and London as a whole into step with how MAPPA has always operated in the rest of England & Wales. This way of working keeps the responsibility for setting a risk level of 1 with the agency holding the case and improves risk assessment and practice in these agencies, rather than reliance upon police and probation to exclusively hold this area of expertise.

There have been three cases managed at level 3, risk of serious harm, for a number of months during 2013/14, involving senior members of staff and complex issues of both child protection and the risk management of child offenders.

Safeguarding is not always a matter of protecting the vulnerable from others. Sometimes, the vulnerable, such as children, can present considerable risks of committing abusive sexual and/or violent acts against other children, staff and others. We have managed two such cases this year, with Hillingdon Council devoting considerable resources to place one such child in specialist foster care. Health has commissioned a specialist assessment.

Since moving over to the new risk level setting arrangements in January 2013, MAPPA in Hillingdon has assessed and set risk management actions on a monthly basis for an average of 12 cases a month. Cases managed at level 1 by the case holding agency do still involve information sharing between relevant agencies and can move in and out of level 2 or 3 at any time, as required.

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

## **UK Border Force**

Section 55 of the Borders, Citizenship and Immigration Act 2009 places a duty on the Secretary of State to make arrangements for ensuring that immigration, asylum, nationality and customs functions are discharged having regard to the need to safeguard and promote the welfare of children in the UK. A similar duty is placed on the Director of Border Revenue regarding the Director's functions.

The duty came into force on 2 November 2009 and is accompanied by guidance.

Heathrow Border Force staff refer to local social services, health services and/or the police where they have a child safeguarding concern regarding a



child or young person arriving in the United Kingdom. Staff contribute to Serious Case Reviews and attend LSCBs as required.

Fortnightly operational meetings are held jointly by the Heathrow Safeguarding and Trafficking Teams and Hillingdon Social Services to review any cases of children and young people arriving in the UK. Quarterly strategic safeguarding forums are jointly hosted by both agencies to replace the merged LSCB sub trafficking meetings and Pan Heathrow Children's meetings.

#### **Main achievements in 2013/4**

Operation Paladin was a locally based arrangement, relying on the support of the Metropolitan Police. Due to changes in the Met the resource provided to the team was scaled back. As a result, Border Force officials looked at how they could continue to provide a safeguarding response at Heathrow, but also how to introduce a more robust national response which extends beyond the London area and provides a better fit with emerging National Crime Agency structures.

Border Force decided to establish new safeguarding and trafficking teams, under existing Border Force arrangements, from April 2014. These teams are responsible for the day to day response at the border to safeguard individuals and prevent and disrupt human trafficking activity and are trained to a higher, more expert level than ordinary front-line officers. The benefits of this approach include:

- it is based on a national approach, rather than a local one;
- the team covers safeguarding and trafficking concerns for both adults as well as children;
- it is more sustainable in the longer term; and
- it provides a better fit with referral pathways into the National Crime Agency.

The new safeguarding and trafficking teams were established and up and running at Heathrow from 1 April 2014. The current Operation Paladin team was disbanded at the same time. To prepare for the establishment of the new teams at Heathrow, all Border Force team members were trained in a 4 day Tier 3 safeguarding and trafficking training package developed within Border Force. A dedicated project team involving MPS and Border force officers was set up to establish the teams, and to mitigate any risks which came from the disbanding of Paladin.

As one of the key benefits from Operation Paladin was its multi-agency operation we have looked to build on the new Border Force teams to ensure police and wider local agency input into the work of the new safeguarding and trafficking teams at ports. Initial discussions with the National Crime Agency suggest there are opportunities to be exploited with the setting up of Joint Border Intelligence units at the Border. In addition, to realise the wider child safeguarding benefits of these teams, officials have explored with CEOP Command how they can use their existing national capability to support and facilitate the development of strong relationships between the new Border Force led teams and individual local authorities where these are not already in

place. This will be key to ensuring the teams benefit from the wider local safeguarding capability and will help reduce the risks of children going missing from care, currently a key concern in relation to our response to trafficked children.

### **The main challenges and developments:**

Any actions and recommendations will be identified where business areas are found not to be meeting their section 55 duty. Well established joint working between Heathrow Border Force and Hillingdon Social Services has been held up as a national example of best practice but remains subject to constant and ongoing review. Since the establishment of Terminal SAT teams joint operational fortnightly meetings have been re-established to examine all arriving Safeguarding and Trafficking cases through Heathrow. The LSCB sub trafficking forum and the Pan Heathrow CYP meetings have also been merged to create a quarterly strategic safeguarding forum chaired by each agency on a rotational basis.

### **Training provided in 2013/4**

A new 4 day intensive course was delivered for the new Heathrow Safeguarding & Trafficking Teams.

Trafficking e-learning has also been revised to make it more Border Force focussed.

## **Cafcass**

Cafcass is a non-departmental public body, sponsored as of April 2014 by the Ministry of Justice. Its principal functions are to safeguard and promote the welfare of children who are subject to family proceedings, and to provide advice to the family courts. It employs about 1870 staff, over 90% of whom are frontline.

In 2013/14 a total of 9,680 care applications (public law) were received, which is a decrease of 12% compared with the number received in 2012/13. Similarly there has also been a decrease in private law cases where a total of 42,888 applications were received in 2013/14 - a 7% decrease compared to 2012/13. Shorter case durations (within s31 cases), together with proportionate working and more efficient working practices have led to the stock of open cases reducing in both private and public law.

The following are examples of activities undertaken by Cafcass in 2013/14 to improve practice, better safeguard children and make a positive contribution to family justice reform:

- Working with partners in family justice e.g. the Family Justice Board, Local Family Justice Boards (11 of which are chaired by Cafcass), judges; the Family Justice Young People's Board; and the ADCS, to promote family justice reform in preparation for the implementation of the Children and Families Act (April 2014).
- Contributing to the development of the Public Law Outline and Child Arrangements Programme (Practice Directions 12A and 12B

respectively); and working with partners to reduce the duration of care cases (35 weeks as of quarter 3).

- Setting up demonstration projects designed to accelerate family justice reform e.g. a telephone helpline service in the North-East to divert from court cases where there are no safeguarding issues.
- Strengthening the workforce through a number of measures including: the talent management strategy; MyWork (a mechanism by which staff can understand and regulate their own performance); development of a health and wellbeing strategy.
- Revising the Child Protection Policy, Operating Framework and Complaints and Compliments Policy.
- Drafting service user minimum standards which will be joined with our work stream on child outcomes.
- Undertaking a number of pieces of research into the work of Cafcass and family justice including research into: expert witnesses in s31 cases; the work of the Children's Guardian; learning derived from Cafcass submissions to serious case reviews (Cafcass having contributed to 30 such reviews in 2013/14).

The National Ofsted inspection took place in February and March 2014. Both private law and public law practice were judged to be good as was the management of local services. National leadership was judged to be outstanding.

All of the Key Performance indicators, relating to the allocation of work and filing of reports, have been met.

## Probation

2013/14 saw a significant change in the way probation services are to be delivered, "Transforming Rehabilitation" (TR). In response to Government's plans to reform probation, dissolve the Probation Trusts and transfer the work to two new organisations: the National Probation Service (NPS) (London Directorate) and the London Community Rehabilitation Company (CRC) came into being on 1 June 2014. NPS and CRC London are now fully operational. The NPS manages all High Risk and MAPPA offenders. The CRCs manage low and medium risk offenders under probation supervision until a contract for this work is awarded in October 2014. The competition for the regional contracts is being managed by the Ministry of Justice and is open to private and voluntary and community sector bidders. There will be payment by results incentives for the new providers. The Community Rehabilitation Companies will be public bodies and the new providers will be also be governed by key requirements, including sharing information with partners. The National Probation Service and the Community Rehabilitation Company are committed to working together effectively.

Each Local Delivery Unit (LDU) has a Children's Champion. There is a Pan London lead who coordinated and delivered meetings centrally with Children Champions (CC) in each LDU, to ensure a coordinated and consistent approach to safeguarding children; best practice has been promoted,

reinforced, facilitated and enhanced via a series of briefings and training events.

New Safeguarding policy was launched by LPT in October 2011 which also had a pan London action plan and procedures included – this will be updated for the new organisations this year. NPS/CRC strategy and business plans will include reference to public protection and safeguarding. Safeguarding Policies and Procedures for all staff are available on our London Internet. The number of staff who have attended the safeguarding training is monitored via the training department. All staff and managers across London have to attend a mandatory 2 day safeguarding training – this has to be refreshed every 3 years. Staff within NPS/CRC are expected to raise any immediate concerns relating to safeguarding with their line manager/Social Care as per the safeguarding policy. Referrals to be completed on all cases where necessary. NPS/CRC staff are subject to regular supervision from their line manager and this involves discussion on high risk cases and those with safeguarding issues.

The CRC will be expected to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children. This will be reflected in the London CRC Contract and Service Level Agreements.

#### **Main achievements in 2013-14**

- There have been quarterly multi-agency seminars for all CCs, the focus being new developments/ perspectives in safeguarding, changes to legislation and impact on practice, integrated working / innovative practice.
- Revision of the LPT Safeguarding children Policy and Procedures, and deployment of those.
- A review of other policies such as home visits, and HR policies has been undertaken to ensure that safeguarding children issues are given priority.
- Representation of LPT on the editorial board for the LCPP.
- Delivery of Safeguarding Children training, in conjunction with LPT Performance Development and Learning Unit (PDL), to various staff groups, including Case Administrators and Receptionists.
- Revision of Pan-London PDL Safeguarding Children training provision and content, in conjunction with the NSPCC.
- LDU briefings and bespoke training events (such as for bail information officers and Community Payback case managers) have been undertaken
- Pan London IT applications that is, London i and ATLAS (safeguarding children and families domains) - have been updated to ensure that staff have access to relevant but current information relating to safeguarding children;
- Production of a Pan-London directory of Children's Social Care Services.

- A Pan London lead SPO for Safeguarding Children has provided consultation for staff working with complex Safeguarding/Child protection cases
- Dissemination of learning across LPT from Serious Further Offences and Serious Case reviews/ domestic homicide reviews.
- Design of a Pan London Section 11 audit template
- Consultation for ACO's in relation to multi-agency audits and HMIP Inspections

### **Summary of the main challenges and developments**

In addition to the challenges of Transforming Rehabilitation in January and February 2014 Her Majesty's Inspectorate of Probation (HMIP) completed an inspection of Adult Offending Work in London Probation Trust. The inspection whilst focused primarily on the quality of generic offender management activity also specifically addressed practice relating to child safeguarding.

The HMIP report published in May 2014 identified 6 key recommendations, with 2 being specific to Safeguarding children:

1. To Safeguard and protect children and young people, checks are made as a matter of routine with Children's services and other relevant agencies and any actions included in plans.
2. Managers provide effective oversight in all cases where the individual poses a high or very high risk of harm to others and/or there are Child protection concerns.

Practice in relation to Safeguarding Children has been a focus for improvement in London Probation Trust (LPT), and it is evident from the recent HMIP report published May 2014 and LEARN the LPT internal monthly audit of case loads locally, using HMIP assessment tools, that London CRC will continue to face challenges in improving Practice in relation to Safeguarding Children. As a result, London CRC, will take a strategic approach to these core Public Protection concerns, to ensure that the organisation meets its Contractual and Statutory responsibilities in these areas, and that London CRC plays a full role in the multi-agency approach to Safeguarding Children, including LSCB audits and Annual Plans.

#### **London CRC Response:**

All HMIP recommendations have been included in specific actions with the CRC Strategic Business Plan 2014/15 and in LDU Local Business Plans.

A 6 point Pan London Action Plan was produced in June 2014, with improvement activity identified for each LDU.

Development of a London CRC approach to Safeguarding Children, practice improvements and learning.

In 2013 Safeguarding briefings took place across London Probation Trust in each Local Delivery Unit. LPT has run monthly internal audits in each LDU (LEARN2) which are performance managed. This enables us to pick up performance concerns by exception. Issues relating to safeguarding are regularly raised and fed into local learning and development.

## LSCB Financial arrangements

The LSCB is funded in partnership by the following agencies: Hillingdon Council, NHS Hillingdon, Metropolitan Police, Probation, Cafcass, and United Kingdom Border Agency. Between them, the Council and NHS Hillingdon contribute over 90% of the total budget. The Council and NHS also make contributions in kind through the provision of an 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 UK Border Agency also contributes through an overall grant made to Hillingdon Council, as a contribution towards safeguarding the needs of vulnerable as a Gateway Authority.

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

The LSCB budget is now considerably under pressure and is showing a deficit for 2014-15 of more than £2000. This will undoubtedly compromise the LSCB's ability to ensure the delivery of effective multi-agency learning and development. In addition the LSCB is obliged to undertake Serious Case Reviews where an incident occurs and the threshold is met. Without further funds the LSCB would not be in a position to commission a review but equally should not, and could not, delay commissioning. A solution to the funding issue is required as a matter of urgency and will need to be resolved within the next reporting year.

## 5 LEARNING FROM CASE REVIEWS AND AUDITS

### Serious Case Reviews (SCRs)

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

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

Case 1. This involved a letter of complaint from a young person with a disability who felt that, over years, he had not been adequately protected from abuse within his family. An independent consultant was engaged to review the case. The review concluded that the complaint was valid that the service received by the young person had not been adequate. No major warning signs were missed but engagement with the family over the years was insufficient and assessments did not take sufficient account of the whole family. The multi-agency input was insufficiently coordinated, though once the abuse was reported the response improved.

It was also noted that the case as a whole had been viewed through a "disability lens" without sufficient emphasis on safeguarding.

A number of appropriate recommendations were made and adopted, including further training on safeguarding for those working with children and young people who have a disability.

Case 2. Involved the death of an adolescent after drinking excess alcohol. CAMHS undertook a "root cause analysis" review. There had been GP and CAMHS involvement with the young person. Following assessment by CAMHS the young man was referred for a further specialist service but sadly died before he was able to access the service. A number of appropriate recommendations were made including ways to reduce the waiting list for therapy and improved liaison with schools.

### Risk Management Panel and multi-agency case review

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

In 2013/4 eight cases were discussed and included cases where domestic violence, drugs, alcohol, adult mental health and learning disabilities were evident. All cases has significant multi-agency interventions.

The general themes identified were:

- Children and young people's views need more attention from the multi-agency perspective.
- Identification of needs and level of risk were generally well done.
- Contingency planning was not always evidenced.
- Multi-agency working appears to be progressing well, but there are elements of miscommunication regarding spelling of names, which is critical.
- All professionals involved need to be updated regularly, even if people are not physically attending core group meetings. It was noted that those who missed Core groups were not always updated.
- Good chronologies are critically important.
- Case recording is not always consistent.
- Turnover of staff has caused difficulties.
- Peer review protocol says each agency should know what the needs of the child are and what services can be provided. CSC and CAMHS did not do so well in this area, on delivering on the area of finance, due to processes.
- Supervision and management oversight – an area CSC could do better in.
- If no legal planning meeting is held, there is not always a 'plan B' in place. It is a multi-agency responsibility that if professionals feel there should be legal intervention; the network works together to timescales, to help the social worker to bring the case to the level which is satisfactory to take to Court.
- Training point – ensure professionals know what to record and how to record risk indicators.

These findings will be tested out as part of Social Care and LSCB audit programmes

### **Single agency audits**

A full section 11 audit was carried out in 2012-13. For 2013-14 each of the key agencies was asked to provide information about their internal case audit arrangements along with the learning and outcomes from these.

This has been an exercise of self scrutiny for partner agencies, as well as the Board. A summary of issues arising from the Section 11 Audit, including recommendations were produced.

The collated results were presented to the Board on 22<sup>nd</sup> March 2013 where the recommendations were agreed and the Chair confirmed that she would follow up the results with individual agencies.

The Chair subsequently met with senior managers from some of the agencies and challenged on some of the follow up actions required. These mainly



related to the need for evidence in some cases. An issue raised with Education was the need to ensure safe commissioning for special need placements.

### **Consultation with children and young people:**

Three focus groups were conducted by Health colleagues at Uxbridge College to see how comfortable young people felt with health professionals. This followed Operation Yewtree and was linked to whether young people would feel comfortable reporting something that felt clearly wrong. Concerns from female students were:

- Confidentiality and parents not being told of personal issues.
- Not knowing how to complain and, if they did, what difference would it make.
- Male students were concerned that they weren't good at looking after themselves,
  - i.e. "junk" food, alcohol, gambling and drugs.
  - Not aware of certain health issues, STDs, male breast cancer and prostate cancer.

Overall themes were that, being younger, they weren't always taken seriously.

Most said that they wouldn't complain because of the long process.

Many were unaware that they could have a chaperone during an appointment.

The main concern for females was being examined by a male doctor as this would make them feel uncomfortable.

The outcomes from this piece of work were communicated through regular safeguarding updates in the CCG newsletter. In addition the young people were told how to arrange for a chaperone to be present if necessary together with information about how to complain if necessary.

The safeguarding nurse has continued to develop these themes.

### **Child Death Overview Panel (CDOP)**

Whenever a child dies in the Borough the circumstances of the death are reviewed to try to learn from this, the most tragic of circumstances of events. Whether the death is an expected one or not the review is undertaken and the learning reviewed by a multi-agency panel with the aim of reducing future deaths.

The review process is shared between Ealing and Hillingdon with the Child Death manager and administrator working across both boroughs.

Where the death is unexpected a rapid response meeting is arranged so that all professionals who worked with the child and family can pool their knowledge about the child, the circumstances of the death and work out how best to support the family.

There were six rapid response Meetings in Ealing and seven rapid response meetings in Hillingdon from 1<sup>st</sup> April 2013 to 31<sup>st</sup> March 2014. All rapid response meetings generated immediate actions for agencies.

The Panel reviewed child deaths in Hillingdon and Ealing identifying action to reduce the risk from avoidable causes of child mortality. One such example is the need to promote better understanding about emergency services amongst families with young children who are newly arrived in the UK. In the year, the panel specifically focused on establishing relationships with external organisations following NHS and Public Health transition and worked on renewed protocols with the Coroner's office.

A Power Point training package relating to all aspects and expectations as well as outcomes of the Child Death Overview Process has been developed and is delivered regularly by the CDOP coordinator to staff at both Ealing and Hillingdon Hospitals and to Health Visitors. Members of the panel attend national training from the Child Bereavement Trust and Lullaby Trust (formally FSIDS).

All parents receive a letter, either after the Rapid Response Meeting or two weeks after the death of their child, explaining the CDOP process and informing them that the CDOP will be gathering information relating to the death from many agencies. The letter invites them to contact the CDOP Manager or if they prefer, their Consultant Paediatrician to discuss the CDOP process or to express any concerns regarding any agency or environmental factors or views about their child's care which should be taken to the CDOP panel with a view to change and to prevent the future deaths of children. Attached to the letter is a leaflet giving details of the process and how to access bereavement services. Although there is a national agreement that parents will not be invited to attend Rapid Response or CDOP meetings the CDOP manager has met with a number of parents with concerns about their child's death as well as wanting to understand the process and CDOP has assisted by linking them with relevant agencies.

Between 1<sup>st</sup> April, 2013 and 31<sup>st</sup> March 2014 there were twenty two child deaths in Hillingdon Borough and thirty one child deaths in Ealing Borough giving a total of fifty three deaths.

Since commencement of the Child Death Overview Panel procedure on 1<sup>st</sup> April 2008 there have been a total of 340 child deaths

- 151 in Hillingdon – 37 (25%) were unexpected
- 189 in Ealing – 53 (30%) were unexpected

### **Ongoing dissemination of learning**

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

## 6 WORKFORCE

### LSCB Learning & Development

#### **Classroom based training**

Multi-agency training was offered to a range of different agencies / schools and nurseries. The table in appendix 5 below highlights the overall attendance for each of the training topics provided.

The LSCB Learning & Development Officer was in post during this period and delivered many of the training topics, therefore no expenditure costs have been attributed to these training topics.

#### **Safeguarding training**

Multi-agency safeguarding training is defined as the a number of courses identified as essential for those who work intensively with children who are subject to multi-agency intervention strategies such as child in need or child protection plans. The LSCB offers this safeguarding training in three parts:-

Part 1: *Safeguarding Awareness e-Learning* module (level 2). This training is available to all partners and is a precursor to the *Working Together to Safeguard Children* course. This is to ensure there is a universal understanding amongst delegates about:

- The types of abuse and neglect a child may suffer
- How they can identify the tell-tale signs
- What to do if they suspect a child is being abused or when a child or adult discloses abuse

All delegates must evidence that they have completed this type of training either via the e-Learning programme or through a training event they attended in their agency before attending the *Working Together to Safeguard Children* course.

Part 2 *Working Together to Safeguard Children* (level 3). This course includes; identifying and responding to safeguarding concerns, referral process and information sharing, statutory guidance and local procedures up to the point of a child protection case conference.

Part 3 *Core Groups and Child Protection Plans* (level 3), includes multi-agency assessment, planning, intervention and reviewing process of children who are subject to child protection plans.

#### **e-Learning training**

In addition to the courses discussed above, a large number of members have completed e-learning training. We currently have 5 e-Learning modules on offer that include:

- Safeguarding Children Awareness

- Child Development
- Safeguarding children from Sexual Exploitation
- Parental Mental Health
- Risk Assessment in Safeguarding

The greatest topic in use is the Safeguarding Children Awareness course and this is largely due to the requirement to complete this prior to attending the Working Together to Safeguard Children course.

### **Refresher training**

The LSCB offers the following refresher training, intended for staff to complete every three years

- *Safeguarding Awareness e-Learning,*
- *Child Development e-Learning*
- *Working Together to Safeguard Children Refresher*

This is to ensure members remain up to date with legislative and procedural developments, research and recommendations from national Serious Case Reviews, as well as local SCRs and management reviews.

### **Total Training usage**

The Local Authority, Schools and Health are the biggest users of the LSCB training programme.

### **Training evaluation**

In January 2014 the LSCB commissioned the Training Sub Group to test a pilot evaluation, to ultimately recommend an evaluation process the Board could put in place to establish the effectiveness of the training programme.

The pilot process was designed to determine if delegates had a good training experience, whether the delegates increased their knowledge or capability and whether delegate had used the learning they gained since the training event. This type of methodology is consistent with the Kirkpatrick Model of Training Evaluation<sup>2</sup>.

The process involved asking delegates to complete an evaluation form at the start of the training event and again at the end. A third, follow up, evaluation was sent to the delegates six weeks after the training event.

### **The Pilot Results**

#### Did the delegate have a good training experience?

There were 88% responses received and the majority of delegates indicated that they had a positive experience of the training event.

#### Did delegates increased their knowledge or capability?

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<sup>2</sup>

<http://www.kirkpatrickpartners.com/OurPhilosophy/TheKirkpatrickModel/tabid/302/Default.aspx>

There were 88% responses received and there is a shift in delegate's responses that indicate a greater level of knowledge attained, with delegates having more confidence in their ability to use the knowledge after the training event.

#### Had delegate used the learning they gained at the training event?

A follow up evaluation was emailed to delegates and the responses collated automatically. The response rate was much lower, 1.7% and as a result cannot be relied upon to determine if the knowledge received at the event has been maintained or used in practice.

#### **An Analysis of the Pilot Methodology**

Reviewing the data collected, we can state that:

- The use of paper based evaluation forms produces a higher percentage of returns than those sent to delegates. This can be attributed to the course facilitator having oversight of the process. However, there is a cost consideration in terms of printing, sifting and collating responses.
- Evaluation forms sent to delegates produces poorer returns both in terms of the number of responses received and the quality of information given. For example, 1 person responded to a course not included in the pilot and only 1 person completed the post event evaluation, as requested, with their manager.
- The questions used in all evaluation forms appear to provide good information in order to analyse the quality of the training and practice benefit.

#### **Board Decision to pilot evaluation of training**

Following a discussion of the at the June 2014 Board meeting it was agreed that for training courses running from Sept 2014, we would continue with the pilot process used to determine if delegates had a good training experience and whether they increased their knowledge or capability as a result. This involves completing an evaluation form prior to and after the training event.

It was agreed that we would adapt the methodology for the follow up evaluation by conducting telephone interviews that ask the same follow up evaluation questions proposed in the pilot. This would only be used for specific courses identified by the Board. For the remainder of 2014/2015 the Domestic Violence - Impact on Children course would be in scope for this follow up evaluation.

#### **Allegations against professionals**

The Local Authority Designated Officer (LADO) role is outlined in Chapter 2 Working Together March 2013 and under the organisational responsibilities in Section 11 of the Children Section 2004. It emphasises the requirement for organisations to contact the LADO regarding an allegation against any

member of staff within one working day of it coming to the employers' attention, or where allegations are made to the police.

The rate of referrals has remained steady over the past year, with a slight decrease. However there has been an increase in historical referrals of abuse. Of the historical cases there has been one conviction, resulting in a custodial sentence of 4 years and the perpetrator has been placed on a sex offender prevention order for life. This case has resulted in compensation claims being made against the Local Authority as the abuse occurred in a local authority school. Further claims are likely to emerge as more victims of the abuse have come forward and inquiries continue to be undertaken by the police.

There are currently 7 other cases of historical abuse that have been reported to the LADO and are being investigated by the local Child Abuse Investigation Team and the Metropolitan Police Paedophile Unit.

In the current climate of historical abuse allegations, the LADO anticipates that that this figure will continue to rise. It is worthy of note that this is a national trend and not unique to Hillingdon.

The LADO continues to be a single point of contact for all agencies referring allegations or concerns about the conduct of paid or voluntary individuals working with children.

Awareness raising of authority relationships in these settings continues to be provided by the LADO in the form of presentations and information sharing. The relationship with partners in education and early years settings is crucial as they have the main responsibility for children in the Borough and are the agencies where most concerns have arisen.

## Private Fostering

The Private Fostering (PF) return for 2013/14 was submitted to the DfE at the beginning of June 2014. This included the following information:

### *Notifications*

- 18 notifications of new PF arrangements were received during the year.
- 17 (94%) of these cases had action taken in accordance with the requirements of regulations for carrying out visits.
- 15 (83%) of these cases had action taken within 7 working days of receipt of notification of the PF arrangement.

### *Arrangements*

- 13 new PF arrangements began during the year.
- 12 (92%) of these PF arrangements had visits made at intervals of not more than six weeks.
- There were 9 PF arrangements ended during the year.

Commentary: The incidence of Private Fostering may well be under-recorded and the LSCB has asked for further analysis to be undertaken in 2014/5.

## 7 HOW WE ARE DOING - THE EFFECTIVENESS OF LOCAL SAFEGUARDING ARRANGEMENTS

### How the LSCB monitors local safeguarding arrangements

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

#### **The Partnership Improvement Plan (PIP)**

This is a spreadsheet that picks up and monitors all actions arising from inspections audits etc. It is monitored at each LSCB meeting and completed actions are signed off by the Board. During the year 15 actions were completed and signed off by the Board. There were 6 actions progressing at the start of the year, and 7 by end March 2014, as actions were completed and new ones added on.

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

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

**Audits.** Each agency carries out a programme of internal audits. Key actions are fed into the PIP and also reported annually to the LSCB. The main statutory agencies are usually asked to complete an annual return to the LSCB identifying their internal audit programme and consequential actions taken. This was reviewed by the performance sub group and the individual action plans from agencies were read. Each agency had identified learning from the audit and these are clear from the returns made and collated.

One regular theme was that the views of children and young people were insufficiently taken into account and the Board will follow this up in future audits. Following the serious case review, schools are now asked to complete a bi-annual safeguarding audit for the LSCB. These are reviewed by the Education officer and reported to the LSCB.

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

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

In October 2013 the LGA were invited to Hillingdon Children's Service to audit a small number (16) of incoming cases. Some strengths were identified, including the audit and quality assurance framework. The review also identified areas for improvement and a SMART action plan was put in place.

In addition to the LGA inspection nine additional audits were undertaken in respect of Fostering, Adoption, Children's Placements, Residential Services, Youth Offending Service, Leaving Care Service, Children with Disabilities and the Asylum Intake Service. The recommendations of all audits were fed back to the Policy Overview Committee of Hillingdon Borough Council.

Between April 2013 and August 2013 all Looked After Children's files were subject to audit and all Child Protection Plans between August and September 2013.

During the period April to October 2013 a wide range of case audits were undertaken across the whole of Children's Services. The audit activity revealed a number of areas of improved practice, especially in relation to front-line services and some aspects of child protection work and the application of thresholds, some of which were externally validated by the LGA safeguarding practice diagnostic. In the front-line services the audits showed some improvements since the last round of auditing in 2012.

### **Effectiveness of local arrangements to safeguard children**

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

#### **Inspection –Ofsted Inspection 2013**

The Statutory Ofsted inspection regime changed in 2013 and Hillingdon were one of the first Authorities to be inspected. Ofsted judge specific areas of practice as Outstanding, Good, Requires Improvement or Inadequate, and also give one overall rating for the Authority

The Ofsted judgements were as follows and are accepted by the Council:

- The experiences and progress of looked after children who need help and protection: Require improvement.
- The experiences and progress of children looked after and achieving permanence: Require improvement.
- The graded judgement for adoption is: Good.
- The graded judgement for the experiences and progress of Care leavers is: Require improvement
- Leadership, management and governance: Require improvement.
- The effectiveness of the LSCB: Requires improvement.

Whilst the overall judgement was one of Requires Improvement the overall finding by Ofsted was that there were no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However the authority is not yet delivering good protection and/or care for children, young people and families.

The following development areas were identified:

- The right decisions about the type of help children and young people need are not always made by some social work managers. This means that a small number of children are being offered services as children in



need of help, instead of as children at risk of harm. As a result, these children might not get the immediate help they need at the right time. Social workers and managers sometimes terminate the help they are offering to families too soon, which can result in a rapid referral for help again, for the same problems.

- When social workers undertake assessments for children who need help, important information from the past is not always included in assessments. This means that the help provided might not be at the right level.
- Officers who chair case conferences and review the plans for children, have too many different tasks to do, and are therefore, in some cases, not making sure that child protection planning is always good enough. When children need a plan to keep them safe, core groups of people who work with children often work well together, but this is not always evident in their written plans.
- Officers who review plans for looked after children have too many children to consider. They are therefore not making sure the written care plans they see are strong enough. This means that tasks are not done quickly enough.
- Social workers can often talk about plans for looked after children's care very well. However, written plans that explain what needs to get better, do not always reach the same standard.
- Sometimes, there are multiple changes of social workers. This particularly affects looked after children who need a stable figure in their lives to plan for their care. Because of this, some looked after children are not being visited often enough or seen on their own enough during visits. In addition, their views are not always recorded as well as they should be.
- Some looked after children do not do as well as they should at school, and the systems for monitoring this need to be improved.
- Young people who are ready to leave care do not have good enough written pathway plans. These plans should provide details about what sort of support they are going to get, and how and when this will happen. Too many young people who leave care do not go on to further education and are currently unemployed.
- Senior leaders do not yet have an effective plan in place to help them make sure services are constantly getting better for looked after children.
- The information that tells senior leaders, social workers and their managers what they are doing well and what they need to do better, is not clear enough. It does not make sure they are informed well enough to consistently improve the services that keep children safe and well cared for.

**Ofsted identified the following strengths:**

- When people who work with children inform social care services that they think children are being harmed, social workers and their partners, including the police, act quickly to investigate and make sure children are safe.
- The introduction of the Children's Pathway programme, to assist the child's journey through social care services, is driven by the Director of Children and Young People's Services (DCS) and has led to some services improving. This can be seen, for example, through the early help offer for children and families. A new early help structure and an early help assessment have been brought in to ensure that families get the support they need, such as parenting classes. As a result, the people who provide early help services now know exactly when they should tell social workers that families need specialist assistance.
- Overall, services to children are improving because the Children's Pathway programme is well understood by councillors, the people who run services for children in the council and their partners. These groups communicate with one another regularly to make sure they know what each other are doing.
- The plan for the council and its partners, to improve the way services are delivered, is presented in an innovative way, bringing together a number of action plans onto a single format and presenting it visually at meetings with people who run services. This shows them what is getting better for children and what still needs to be done.
- Some partnerships which keep children safe are strong. For example, social workers and the police work together with children who are at risk of sexual exploitation and with families who are experiencing domestic violence. Work with partners to help unaccompanied asylum seeking children coming into the country is a particular strength in Hillingdon.
- The majority of children in care live in places that support them well, and the council works hard to make sure that those places can be permanent.
- Therapeutic support is offered to all children in care, including those who live outside the Borough. The council is highly committed to helping looked after young people to achieve stability where they live.
- Care leavers have good relationships with their social workers and personal advisers who know them well, and help them get ready to leave care.
- The Local Authority is good at placing looked after children for adoption when this is what they need, and then supporting the adoptive family before and after the court order is made.

### **Ofsted's inspection of the LSCB.**

Ofsted's overall judgement in respect of the LSCB was that it requires improvement. The following areas for improvement were identified:

- Ensure that time allocated to LSCB meetings is sufficient for partners to effectively undertake its work.
- Improve the communication with other strategic bodies such as the Health and Wellbeing Board, to ensure strategies aiming to improve the lives of children and young people are effectively co-ordinated.
- Ensure that the LSCB effectively evaluates safeguarding performance through audit and performance monitoring of multi-agency activity, and makes sure the evaluation is used to improve services.
- Ensure that the LSCB provides effective challenge to partners and holds partners to account to improve safeguarding outcomes for children and young people.
- Ensure that children, families and the community are appropriately engaged in the work of the LSCB strategically and operationally, so that its work reflects their views.
- Ensure that partners are appropriately engaged in developing and delivering multi-agency aspects of the signs of safety approach to risk management, so that there is full multiagency engagement in identifying risks and strengths to keep children safe.
- Ensure that the impact and effectiveness of multi-agency safeguarding training is evaluated so that its effectiveness can be assessed and improved.

### **Key strengths and weaknesses of the LSCB**

- The LSCB complies with its statutory responsibilities. The Annual Report has recently been produced and it provides a comprehensive review of the work of the Board, and demonstrates how the Board, through its partner agencies, co-ordinates work to safeguard children in the area. Clear priorities are set out in an achievable and measurable action plan. One priority, to engage children, families and the community, has not been sufficiently progressed at either strategic or operational levels. Therefore its work does not reflect children's views. This commitment has, however, been renewed, together with an undertaking to make effective use of the lay members appointed earlier this year in this regard.
- The terms of reference for the LSCB are clear but need to be refreshed to encompass its developing role. Governance arrangements are appropriately established between the LSCB, the Local Authority's Chief Executive, senior managers and the Children's Trust. However, protocols between the LSCB and other key partnerships such as the

Health and Wellbeing Board and the Community Safety Partnership have yet to be formalised.

- The role of the LSCB Chair is sufficiently independent. The LSCB Chairman also chairs the Adult Safeguarding Board (ASB), which benefits from communication across both boards and provides an opportunity for members to meet, as the boards sit on the same day. The LSCB has recognised the time allocated to both the LSCB and ASB components is insufficient to enable appropriate governance, and plans are in place to increase the time allocations for these respective meetings. The LSCB is at an early stage of developing oversight of, and involvement in, early intervention. It has influenced the development of the early help assessment and Team Around the Family plan replacing the Common Assessment Framework.
- Performance management and analysis are not sufficiently well developed within the Board. The LSCB monitors front-line practice by individual partner agencies through a range of individual agency audits and performance management information. Issues arising from these are routinely considered by the LSCB performance sub group and are reported on to the Board. However, monitoring and evaluation on a multi-agency basis is underdeveloped at this stage. The LSCB introduced multi-agency audits very recently and only eight cases have so far been reviewed with limited impact as yet on the safeguarding system. Prior to the implementation of the multi-agency audits, the LSCB carried out comprehensive management reviews on four specific cases in 2012/2013.
- Whilst the LSCB has reviewed some key areas of performance; others have not yet received sufficient analysis, in particular, the significant drop in children subject to child protection plans and the significant rise in the proportion of children subject to repeat plans. This lack of scrutiny has occurred in the context of the board acknowledging concerns about the smartness and effectiveness of child protection plans, staff turnover and the quality of assessments and management oversight.
- The LSCB has also not ensured that the multi-agency implications of the roll out of the signs of safety approach have been systematically addressed. This is particularly within child protection conferences, so that the whole partnership is engaged in this approach to recognising risks and strengths in families in keeping their children safe.
- The LSCB regularly receives updates from member agencies, which enable partners to have a clear understanding of issues affecting the delivery of safeguarding services across the local area. For example, updates detail any significant organisational and staffing changes, staffing shortages and the need to improve the quality of some aspects of child protection practice and management oversight. Whilst this is information sharing, there is little evidence that it results in effective challenge to partners, or holding partners to account, in a way that that improves the delivery of services or outcomes for vulnerable children.

- Safeguarding is a priority for all key partners. There is appropriate representation of partner agencies within the sub/working groups of the LSCB. However, the LSCB annual report demonstrates that over the last year, representation by some partners at the LSCB meetings has significantly decreased from the previous year. However, the LSCB chair has undertaken significant engagement with partner agencies and through the London Safeguarding Board, to improve partners participation and attendance.
- The LSCB has established appropriate priorities based on local needs and is prompt to respond to emerging local and national issues. Safeguarding Audits under Section 11 of the Children Act 2004, were completed last year by partner agencies, confirming that all partners are appropriately prioritising safeguarding.
- Effective systems are established to ensure child sexual exploitation, trafficking, missing children and child deaths, are appropriately overseen by the Board. The LSCB is aware of the need for all partners to improve private fostering notifications. However, specific action to raise awareness and notification of children privately fostered in the local schools has not yet been successful and as a result, the number of notifications currently remains low.
- Whilst no local Serious Case Reviews (SCRs) have been recently undertaken, the LSCB has implemented learning from previous SCRs and national findings, alongside learning from individual agency reviews. Learning is incorporated well into the extensive LSCB training programme which is well established and is well attended by partner agencies. LSCB training is responsive to the Board's priorities and partner agency's needs. For example, it is now providing signs of safety training for partner agencies. However, the evaluation of the impact of training is at an early stage of development.

### **Children's Resources Ofsted ratings**

Children's Resources Service is responsible for the management of the London Borough Hillingdon's Fostering, Adoption & Permanence, 3 Children's Homes, 1 semi independent unit, the Access to Resources Team & the Contact Service.

The Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers in December 2013 included a focus on Adoption services and judged the performance as "Good" identifying this area as one of the Local Authorities' strengths;

"The Local Authority is good at placing Looked After children for adoption when this is what they need, and then supporting the adoptive family before and after the court order is made"

Although Fostering was not separately inspected as part of the Ofsted inspection, a number of areas of practice were scrutinised as part of the Adoption rating, and fed into the "Good" outcome.

The Children's homes are inspected by Ofsted twice a year. There is one full inspection, and one interim shorter inspection that focuses on the action plan from the full inspection. The Full inspection grading are in line with the Local Authority inspection process and the interim inspection measures Inadequate progress, Satisfactory progress or Good progress.

Merrifield House, (8 bedded resource centre for children with disabilities) was inspected on 07.05.13 and received a "Good" rating. There were no requirements, and 2 recommendations. The recommendations were to have the ground floor redecorated, and for supervision to be provided to Agency staff by appropriately qualified and experienced staff. Both have been addressed.

The subsequent interim inspection on 28<sup>th</sup> March 2014 resulted in an "Inadequate progress" judgement being made.

This judgement was based on a number of technical issues, which did not relate to the full inspection recommendations or to the direct care of young people. This judgement was subsequently challenged and some minor amendments made to the final report. All the actions from this inspection have been completed. A full report was presented to POC on 10<sup>th</sup> September. We anticipate we will retain or improve on the current Good rating at the next full inspection.

Hillingdon Children's Resource Centre (Mulberry Parade) (6 bedded resource for local young people)\_had its last full inspection on 4<sup>th</sup> June 2013 in which it received a "Good" judgement. The follow up inspection on 12<sup>th</sup> December 2013 identified 2 areas for improvement which were:

- Notify Ofsted without delay of any event specified in Schedule 5, including any suspected involvement of a child accommodated at the home in sexual exploitation (Regulation 30(1), Schedule 5)
- Ensure that the home is visited in accordance with Regulation 33 and that a copy of each monthly report is sent to Ofsted in a timely manner (Regulation 33(5)).

This resulted in a rating of "Inadequate progress".

The above areas have been addressed and are being robustly monitored through care practice audits, manager's audits and the Independent regulation 33 Officer.

We anticipate we will retain or improve on the current "Good" judgement at the next full inspection.

Charville Lane, (13 bedded unit for unaccompanied asylum seeking young people) had its last full inspection in April 2013 and received a judgement of "Good". The interim inspection on 26.03.2014 found the home has made "Good progress." There was one recommendation, "to review the Statement of Purpose and the Children's Guide at least annually". This was completed and the Statement of Purpose presented to, and approved by, the Corporate Parenting Board on 1.5.2014.

The 3 homes are due a full inspection in the next year. It is anticipated they will all retain or exceed the judgement of "Good."

## **Children at risk through trafficking or sexual exploitation**

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

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

The other operational group which sat beneath the Trafficking Sub Group was the multi-agency meeting that addresses issues relating to children who were reported missing within the community. This group included active involvement from the Public Protection Desk of the Borough Police, and also had 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 identified a small cohort of approximately twenty children (mainly local children) who led 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.

During the year Children's Social Care and the Metropolitan police worked collaboratively on a potential child sexual exploitation (CSE) case. This case came to trial in 2014 resulting in conviction and sentences. The LSCB was pleased to see that the inter-agency cooperation ended positively but is keen to see more preventative work in place so that children and young people at risk of CSE can receive the input necessary to identify them earlier.

## Child protection

### Child Protection (CP) Plans

There were 192 children subject to a CP Plan at the end of April 2014. This figure has been on the rise since January 2014 (174) when the number of children on a CP Plan was at its lowest in two years.

The 2014/15 target for the s47-to-ICPC conversion rate is 70%. Increasing the number of s47's that proceed to an ICPC will mean that resources are used more effectively in addressing concerns of an appropriate level and that children will receive the right help they need given in their circumstances.

A further target around the timeliness of Initial Child Protection Conferences has been set around the percentage completed within 15 working days of a s47 enquiry starting (100% for 2014/15). Progress against this target will be reported over the next year.

### Second or Subsequent (CP) Plans

3 out of the 18 CP plans started in April were second or subsequent plans. The percentage of cases that were subject to a second or subsequent CP plan (17%) is above the target of 7% set for the year. The result for 2013/14 was 15%.

### Child Protection (CP) Case Review

79% of CP cases were reviewed within timescale, as recorded on ICS Protocol, at the end of April. System workflow issues continue to distort performance as discrepancies between system data and manual checks persist. Manual checks of outstanding case reviews generated by ICS indicate that 96% of these are being completed on time. Ongoing work is being conducted through performance challenge meetings to improve the quality of data held on ICS.

### Child Protection (CP) Statutory Visits

97% of visits were completed within the 6-week timescale. 60% of visits were recorded as 'seen alone'. April data shows that 101 visits did not record whether the child was 'seen alone' or not - amendments to this information on ICS Protocol may result in an improved figure. A target of 90% for 'seen alone' has been set for 2014/15.

### Children with disabilities subject to CP procedures.

Over the year 2013/4 a total of 24 children and young people with a disability were subject to s47 enquiries. One of these went into legal proceedings; eight to an initial child protect conference and two to children in need. This does appear to be a low figure and will be subject to scrutiny over the coming year.



## Single Assessments

Of the 2,267 single assessments concluded since its inception in November 2013, 79% have been completed within the 45-day timescale. The timeliness of completed assessments has been recorded as falling over the last six months of 2013/4.

This is being monitored on a weekly and monthly basis through performance challenge meetings as well as in supervision and line management. Social work teams are undertaking a review of assessments to ensure that case closure is ended where necessary with deputy team managers in the process of signing off outdated assessments.

The 2014/15 target for percentage of assessments carried out within 45 days of referral has been agreed at 85%.

## Looked after children and care leavers

There were 347 looked after children at the end of April 2014. This is the lowest number of LAC recorded over the last three years. Changes in trend continue to be tracked in order to minimise adverse impact on placement budgets and regulate social care workloads.

82% of LAC statutory visits at the end of April were completed within the 6-weekly timeframe. This information originates from the child's record on the ICS Protocol system. A target of 100% has been set for 2014/15.

In their inspection in November-December 2013 Ofsted's judgement was that performance in respect of Children Looked After was that it required improvement. Good practice was identified and, by and large, workers acted swiftly and decisively at the beginning of proceedings. Visits, however, were not always timely and plans not always well and comprehensively written.

Concerningly educational attainment is below that of other looked after children at all stages.

Routes to permanence were commended and siblings were usually placed together.

The experience for Care leavers was also graded inadequate. Some Care leavers were highly complimentary about the service they had received and good relationships with both social workers and personal advisors was noted. However written pathway plans were not always of a good enough standard and fewer Care leavers were in education than their peers.

The LSCB is developing a protocol with the Corporate Parenting Board to ensure that relevant safeguarding information is considered by the LSCB

## Young carers

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

In 2013/14 Hillingdon Carers worked with over 385 Young Carers living within Hillingdon, 15% of these were aged less than 7 years old. The continued increase in referrals (187 within the year) indicates improved awareness of Young Carers and this is largely due to the outreach undertaken by Hillingdon Carers to schools, GP surgeries, social services departments and other organisations within the Borough. Locally, 48% of Young Carers are in single parent families and many of these are supporting parents with mental health and/or substance misuse issues. 50% of our registered Young Carers are caring for their mother with the majority of the remainder (27%) caring for a sibling. Mental health of a parent continues to form the largest group overall (48%) followed by sibling carers with the remaining majority caring for a parent with a physical or sensory disability (24%).

Young Carers registered with Hillingdon Carers are visited by a support worker where an assessment is carried out and a pathway plan is produced. The pathway is completed with the Young Carer and parent (where appropriate) and identifies needs, looks at aspirations and sets future goals with a date for review. Each pathway is scored on a number of factors and this determines the levels of support received (intensive 1:1 or clubs/trips and activities) and the review period. All Young Carers are technically a 'child in need' but only a minority require support plans; 23 Young Carers supported by Hillingdon Carers have child in need plans and 18 are subject to a child protection plan.

## **Children who experience domestic violence**

Estimates based on national research suggest that over 10,000 children and young people locally will have been exposed to domestic or family violence in a lifetime, and over 2,200 in a year ( JSNA) 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 mental illness are present.

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

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

The LSCB has expressed concern about the lack of provision to support children and young people who have experienced emotional harm through living with domestic violence. In 2012-13 funding was provided for a local

housing association to provide support for children placed in the refuge and for those in the community through workshops. Outcome information is not easily available, but anecdotal evidence from staff is that the improved risk assessments and joint communication has greatly improved the safety of many families and children, including development of a child protection plan when appropriate.

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

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

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

It is also known that those children who experience abuse directly are more likely to become perpetrators themselves. This includes the increased numbers of teenage perpetrators. The Youth Offending Service includes domestic violence in its work programmes with young offenders

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

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

## Potential risks to safeguarding

### Resources

The lack of sufficient competent and permanent staff continues to pose a risk to safeguarding children. The main risks represented are lack of supervision and management oversight and the impact of a changing staff group on continuity of communication both with other agencies, and with children and their families. It can also lead to unnecessary drift.

Social care staffing has been characterised by high numbers of agency staff and a large number of interim managers. Steps are being taken to address this in 2014.

The staffing issue is most marked in social care, but is also apparent in other agencies, e.g. Police. All agencies have had to reduce spend, which inevitably leads to difficulty in responding quickly and appropriately to need

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

### **Reorganisation**

Virtually every organisation is, or has recently reorganised. This is sometimes due to the need to make savings, sometimes to manage new government requirements, and sometimes to increase the effectiveness of services. These reorganisations create opportunities, but also risks. There are inherent risks in staff losing focus in the midst of change and some consequential increase in vacancies. There are also potential direct risks to services

### **Lack of coordination of early intervention work**

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

### **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.

The working relationship between Heathrow staff and both Children's Social Care and the LSCB is an excellent one that allows for the positive promotion of safeguarding.

### **Inspection and quality assurance**

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

## **Potential opportunities to improve safeguarding**

### **Staffing**

In spite of the concerns raised above, on the whole children are effectively safeguarded in Hillingdon through the efforts of skilled and hard working staff across all agencies. There is much evidence of staff working and communicating well with each other and with children and their families. The LSCB will continue to ensure the delivery of a strong multi-agency training programme and will do more to engage with staff and obtain their views.

There is a strong senior management commitment to safeguarding across agencies and, on the whole, a willingness to be held to account by the LSCB.

### **Reorganisation**

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

### **Signs of Safety**

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

Signs of Safety was fully launched in July 2014 so any evidence of impact will not appear until early 2015

### **Inspection and quality assurance**

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

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

## 8. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

### **Working Together 2013 and London Child Protection procedures**

This guidance issued in March 2013 made several important changes to the existing safeguarding children framework.

The new guidance focussed strongly on legislative requirements, and removed large sections of non-statutory practice guidance.

#### Key changes

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

The significantly slimmed down 2013 edition of Working Together was intended to reduce the burden on professionals who felt compelled to follow a wide range of prescriptive guidance, which the Munro Review of Child Protection considered to have created an over- bureaucratized culture that stifled local innovation and professional judgement. Therefore, much of the good practice guidance contained previously in Working Together has been removed, and the Government intends that practice guidance will no longer be

centrally issued. Instead, individual sectors are encouraged to lead on the development of their own professional guidance, informed by local research and evidence.

### **London Child Protection Procedures 5<sup>th</sup> edition**

Further to the publication of the revised National Guidance *Working Together 2013*, the London Child Protection Procedures have been rewritten, and were launched at the London Conference in December 2013. They were adopted by Hillingdon LSCB in March 2014.

### **The Savile case**

The public awareness generated by the Savile case may have led to an increase in safeguarding referrals, concerns and awareness. It has certainly been a reminder that no one is exempt from scrutiny. The learning has extended to organisations who have been compelled to consider their governance and safeguarding arrangements.

This is the only positive that has emerged from what has been the most awful experience for so many.

### **National Health Service**

#### **Clinical Commissioning Group (CCG)**

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

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

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

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

### **Local Developments**

#### **Children's Pathway Programme**

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

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

A number of work streams have been developed, which have included a number of pilots around better ways of working with families. These include "keyworking" services in tiers 1 and 2, and "POD" working in statutory

services. The Children's Pathway Programme is continuing to drive all the changes mentioned below:

### **Single Holistic Assessment**

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

### **Early Help Assessment and multi-agency referral form**

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

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

Both of these were developed by practitioners across agencies and piloted prior to full roll out in summer 2013. They were subject to full consultation by operational staff and agreed by LSCB in autumn 2013

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

### **Signs of Safety (SOS)**

Hillingdon Local Safeguarding Children's Board adopted the "Signs of Safety" (SoS) approach to working with families where there are concerns about children's safety.

The launch of the SoS came into effect on 9th July 2014. This approach aims to work with the strengths and resources that exist within families to build safety for children who have suffered, or are at risk of suffering significant harm of physical, sexual and emotional abuse and neglect.

The SoS approach considers information about the child and their family across a number of areas, for example:

- \_ Why are we worried about this child?
- \_ What are the dangers/risks?
- \_ What are the complicating factors or 'grey' areas?
- \_ What is working well in terms of existing strengths?
- \_ What is working well in terms of existing safety measures that are in place?
- \_ How worried are we on a scale of 0 to 10?
- \_ What outcomes (or goals) do we need to have to build safety for this child?



\_ What needs to happen to make the necessary changes to achieve this outcome?

A number of tools and resources including leaflets for parents and carers, children and young people and professionals have been created and are available to download from the website ([www.hillingdon.gov.uk/article/28746/Signs-of-Safety-approach-to-child-protection](http://www.hillingdon.gov.uk/article/28746/Signs-of-Safety-approach-to-child-protection))

### **Multi-Agency Safeguarding Hub (MASH)**

The Hillingdon MASH was soft-launched at the beginning of October 2013, with representation from health visiting, police and children's social care. The outline processes were described as being based on those issued by the London Safeguarding Children Board, with the aim of developing these further as other partners joined the local MASH. As at September 2014 the MASH has not engaged all partner agencies and was reliant upon regular input from Children's Social Care and the Police. The intention is still that the MASH will be multi-agency and the LSCB strongly supports this and would urge that the timetable is expedited.

### **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 has been supported through the further development of safeguarding clusters across the Borough.

However, in early 2014 we have had to instigate a Serious Case Review related to an incident of abuse in a school. This raised into question the success of our engagement with schools as some very basic safeguarding messages appear to have been lost.

Although the SCR will not complete until the end of 2014, early discussion has been held with LSCB head teacher representatives and schools forum about key messages.

## **9 WHAT WE NEED TO DO: priorities for LSCB 2014 onwards**

Our evaluation of the progress against our priorities plus our assessment of the effectiveness of local safeguarding arrangements, consideration of relevant national issues and feedback from staff have led us to identify the main priorities for the Board's work from 2014.

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

The Ofsted judgement for the Board, and for local authority services was 'requires improvement'.

We developed an implementation plan that reflected the findings from the inspection, and is detailed in accordance with the main areas for improvement as identified by Ofsted.

A special workshop of the LSCB was convened in January 2014 to agree the main priorities for improvement. The full plan was ratified in March 2014 and submitted to Ofsted as required in June 2014.

**Priority 1 Ensure that time allocated to LSCB meetings is sufficient for partners to effectively undertake its work**

- Review the structure and governance of LSCB and increase time available for meetings
- Revise staffing arrangements to provide for a dedicated Business and Development Manager
- Reduce and align sub group and working group activity with statutory responsibilities and local priorities
- Establish an Executive group to focus on LSCB management and communication
- Cease joint LSCB/SAPB meetings and replace with joint children and adult working group

**Priority 2 Improve the communication with other strategic bodies such as health and Wellbeing Board, to ensure strategies aiming to improve the lives of children and young people are effectively coordinated**

- Establish communication protocols with the LSCB and other strategic bodies – Health and Wellbeing, Community safety, Childrens Trust, Domestic Violence Forum, Corporate Parenting Board

**Priority 3 Ensure that the LSCB effectively evaluates safeguarding performance through audit and performance monitoring of multi-agency activity, and make sure evaluation is used to improve services**

- Establish a combined performance and quality sub group
- Establish a scorecard of performance data
- Further develop the multi agency quality audit report
- Update procedures for Serious case reviews as per Working Together 2013

**Priority 4 Ensure that the LSCB provides affective challenge to partners and holds partners to account to improve safeguarding outcomes for children and young people**

- Refresh and relaunch LSCB escalation policy
- Establish Executive group as LSCB 'engine room'
- Review LSCB membership and clarify roles and expectations of Board members
- Ensure that chairing responsibility for sub/working groups is shared equally across the partnership
- Refocus LSCB efforts on setting strategic priorities, monitoring impact of activity and quality of outcomes, providing challenge and support

**Priority 5 Ensure that children, young people and the community are appropriately engaged in the work of the LSCB, strategically and operationally, so that its work reflects their views**

- Map existing user and community engagement arrangements across the partnership to capture existing activity
- Undertake an annual user survey
- Introduce a post conference interview/structured conversation with parents/carers where children have recently ceased to be subject of a child protection plan
- Regularly review complaints comments and compliments to learn from feedback
- Establish a programme to engage proactively with the faith communities
- Consider the use of cyp and parent/care champions to advise and consult on user views
- Establish a shadow Board /ask youth Council to establish a safeguarding group
- Underpin all user engagement with a comprehensive and overarching communications strategy

**Priority 6 Ensure that partners are appropriately engaged in developing and delivering multi agency aspects of the Signs of Safety approach to risk management, so that there is full multi-agency engagement in identifying risks and strengths to keep children safe**

- Establish a SoS implementation group with clear leadership and present implementation plan to LSCB
- Progress key operational tasks
- Agree launch date
- Establish communications strategy
- Evaluate and review after six months

**Priority 7 Ensure that the impact and effectiveness of multi agency safeguarding training is evaluated so that its effectiveness can be assessed and improved**

- Change the current model of delivery from an in house resource to a commissioning resource and include an evaluation as part of the commissioning specification
- Initiate the London SCB training evaluation methodology

## **Individual agency plans**

### **Youth Offending Service**

- Review the Combined Risk, Intervention and Safeguarding panel to ensure that it remains fit for purpose in meeting its stated objectives with respect to vulnerability and risk management.
- Develop and implement a custody improvement plan based on analysis of custodial sentences imposed on Hillingdon young people.
- Using Youth Justice Boards Re-Offending Toolkit analyse data on re-offending behaviour and the characteristics of those perpetrating it so that prevention strategies can be developed and resources allocated
- In conjunction with the Hillingdon Corporate Parenting Board, complete review of existing services for children and young people placed from home who offend against the good practice and recommendations contained in the HMIP Inspection report on Looked after Children (Dec 2012).

### **Early Intervention Services**

- Enacting any organisational change that arises as a consequence of the early support review;
- Continuing to maintain and improve performance levels in the Troubled Families programme. 'Turn-around' rates are slowing. Many of the remaining families in the phase 1 cohort are likely to have more complex needs and issues to address which will make resolution more challenging;
- Meeting the increasing demand for early intervention key-work services; and

Establishing consistent and effective data sharing arrangements across partners including those concerned with supporting vulnerable children such as those missing education.

### **Central and North West London Trust Mental Health and Community Services**

- Reviewing the structures for Safeguarding Children within the Trust
- Raise awareness of private fostering procedures as the low number of referrals and currently known privately fostered children suggests that the

issue is yet to be fully embedded in practice

- All Health Care Professionals working directly with children, from birth to 18 years of age, will have access to child protection supervision
- Carry out clinical audits to ensure a safe, quality service is in place and that local and national standards are followed. The Hillingdon Safeguarding Children Team will inform clinical leads where gaps in service provision exist and work together to develop action plans to bridge any identified gaps
- Raise awareness of female genital mutilation with health care professionals via training and supervision. In addition the training programmes will be amended to highlight FGM
- Health staff are ideally placed to help identify and provide support for those at risk of child sexual exploitation. The Hillingdon Safeguarding Children Advisor attends the multi-agency child sexual exploitation group and the Safeguarding Children Team have adapted training material to ensure health staff are aware of how potential or actual victims may present and what the local arrangements are
- Raise awareness in relevant staff groups within Hillingdon's children's services to ensure they are able to identify and support missing children and runaways
- Promote awareness in Hillingdon of the new threshold criteria adapted from the London Board Levels of Need and ensure health professionals consistently apply the thresholds
- Monitor the relationship of the Trust staff with the MASH and contributing to MASH evaluations. Support health staff during MASH implementation in Hillingdon. Ensure Hillingdon staff access the MASH training courses
- The Hillingdon Safeguarding Children Team will support health professionals with the new Signs of Safety approach to assessment, intervention and case conferences.
- Publicise the Think Family agenda more widely
- Increasing the safeguarding children training for Consultant staff
- Monitoring uptake of safeguarding children training following the new Learning and Development Zone
- Adapting the Named Nurse meeting to provide peer group supervision
- Develop Safeguarding Children Strategy
- Planning for implementation of the new IT System and reporting of data

### **The Hillingdon Hospital**

An annual work programme has been developed to ensure priorities for 2014/15 are closely monitored and that 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:

The ongoing recruitment of more paediatric nurses to the paediatric Accident and Emergency (A&E) department.

To refresh/ re-evaluate the liaison between Social Care and A and E at the weekly 'Safety Net' meetings.

To achieve and then maintain 80% in levels 1-3 safeguarding children training. This will be achieved by the provision of additional Level 3 days for this period for Trust staff, in addition to other training being provided.

To ensure that the recording of self-harm data within the A and E department is as accurate as possible, with a proposed audit at the end of the year to monitor.

Revision of the Trust safeguarding children policy

The implementation of the MASH and SoS

Meeting the increasing demand for safeguarding information

## **CAIT**

The performance objective for the current year is to improve on 2013-14 detections. The challenge is to achieve this alongside a 20% reduction in costs over 4 years.

## **Probation**

Both NPS and CRC are committed to effective Inter-agency working to safeguard & promote the welfare of children. NPS/CRC Assistant Chief Officers or deputy will continue to attend LSCB Boards. LPT Offender Managers attended case conferences when necessary and contribute to Section 47 investigations/CP plans. This will continue in the NPS/CRC. NPS/CRC is looking currently to develop the work done with offenders/families in order to improve overall service delivery to families. LPT has run monthly internal audits LEARN2 which are performance managed. This enables us to pick up performance concerns by exception. This auditing will continue in the NPS/CRC. LPT had a corporate and local induction process in place for all new staff. This will continue in the CRC/NPS. NPS will continue to chair regular monthly MAPPA meetings and also attend monthly MARAC meetings. Both meetings look to manage risk and ensure that appropriate risk management plans are in place for the offender and victims/children. CRC staff will be involved as appropriate.

## **UK Border Force**

We will continue to build on the already considerable achievements of the Safeguarding and Trafficking teams and work with other agencies to carry out frontline operations to identify potential victims of trafficking or FGM.

Although special waiting and meeting areas are available at each Heathrow terminal and routinely used for CYPs encountered some holding rooms are more suitable than others. An accommodation refurbishment and improvement work project is being progressed to ensure improvements benefit children and families held in port short term holding facilities whilst meeting operational needs. Work will take place across all four Heathrow holding rooms with a specific focus on ensuring our accommodation is child and family friendly.

## 10 CONCLUSIONS AND ISSUES FOR THE CHILDREN'S TRUST AND OTHER BODIES

Council Services and the LSCB were both given a judgement of 'requires improvement' by Ofsted at the end of 2013.

We accept this judgement, which we believe is realistic.

Many positives were noted across our partnerships and the LSCB wishes to pay tribute to the many dedicated and hard working staff across all agencies who have total commitment to safeguarding children, and to the managers who support them

On the whole, agencies respond swiftly to act on concerns and there is evidence of sound partnership work on the ground. This is evidenced particularly in activity to prevent trafficking, children going missing and those who are a risk of sexual exploitation. Good services are in place to support those affected by domestic violence. Early intervention services have developed and more families are now receiving coordinated early support based on whole family needs. Work around understanding child deaths and in managing staff allegations is strong and there is an effective multi agency training programme.

Following the Ofsted inspection, challenging action plans were developed for the Council and the LSCB for 2014-15. Although there has been progress, this has been impeded by a shortage of permanent staffing in children's social care, which impacted also on the capacity of the LSCB.

This has been addressed in year by some stability in service management, and by the decision by the Council to buy in a managed social work service. It is hoped that these measures, and consequential reduction in caseloads, will enable social workers to improve the quality of assessment and care planning for children in need and those looked after or leaving care.

All agencies have experienced change and resource reductions, which has a potential effect on the quality of safeguarding work. A small but significant increase in the number of cases referred to the Serious Case Review Panel indicates some concern about casework among vulnerable children and young people.

It is also important that the work carried out on threshold and the early help assessment improve the early intervention that is available for families needing help. These must be backed up by the availability of appropriate services. There has been a strong commitment to the MASH from social care and the Police but other agencies need to be fully engaged in order to make best use of the multi agency information sharing that is such a critical element of this initiative.

In previous annual reports the LSCB has expressed concerns about the availability of mental health services for children, at all levels but particularly at tiers two and three. The evidence from the JSNA indicates higher than average numbers of young people reporting to A&E because of self harm and alcohol misuse. At the same time lower than average referral acceptances by CAMHS was noted. Our work in the LSCB raises concerns about self harm



and potential or actual suicide among young people, the emotional harm caused by domestic violence, and the need for additional CAMHS time for specialist need, such as for young people who sexually abuse others. It is acknowledged that the capacity of the current commissioned CAMHS service is limited impacting upon the ability to meet the needs of all children in the Borough. A CAMHS review has been started but progress has been frustratingly slow and the LSCB is very concerned about the lack of support for children's emotional wellbeing available in Hillingdon

LSCB's partnership with schools needs to develop further as evidenced by an ongoing Serious Case Review. There also appears to be an increase in children permanently excluded, missing from education and educated at home. These are all potentially vulnerable groups and the LSCB wishes to engage more closely with schools and with Education to identify and address the issues

Partnership with Health agencies is strong, but further work is needed with GPs as providers and with NHS England, who have not been represented on the LSCB. Some commissioning for children still appears to be not well coordinated.

There has been much positive work with Youth Offending, Police and the Border Agency to identify and support young people at risk. But we need to ensure that high standards are maintained and to get a better assessment of the degree of risk from such things as gang activity, and some cultural issues such as female genital mutilation

There has been no reduction in the impact of some of the more intractable problems such as domestic violence, mental illness and substance misuse among parents, and long term neglect –often not identified until adolescence.

The LSCB itself has been struggling to resource its work. We have suffered from lack of capacity to fully undertake our scrutiny and monitoring role, particularly our quality assurance and case review work. Numbers of Serious case reviews is set to increase in 2014-15 and this has considerable resource implications. There has been an impact too on our ability to deliver a full multi agency training programme, which, along with Serious case reviews, are statutory responsibilities.

The LSCB is also concerned about the high levels of poverty in the Borough – particularly in the southern wards, where over 40% of children and young people are deemed to live in poverty. The figure for the Borough as a whole is over 25% which is high for an ostensibly affluent Borough.

## **APPENDIX 1: LSCB membership**

### **Chairman and officers of the LSCB**

**Lynda Crellin - Chairman (Independent)**  
**Maria O'Brien – Deputy Chairman, Divisional Director of Operations, CNWL NHS Foundation Trust**  
**Gary Campbell, Assistant Director, SC&QA Service, CSC**  
**Alan Critchley, LSCB Business and Development Manager**  
**Carol Hamilton - Manager, Child Death Overview Panel (CDOP)**  
**Andrea Nixon - Schools Child Protection Officer**  
**Janice Altenor - LADO**  
**Joseph Matia - LSCB Legal Advisor**  
**Julie Gosling - LSCB Administrator**

### **Observers**

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

### **Local authority representatives**

**Tony Zaman, Corporate Director, C&YP Services**  
**Dan Kennedy - Interim Chief Education Officer**  
**Lynn Hawes - Service Manager, Youth Offending Service, and Family Key Working Service**  
**Ann Nardecchia - Learning and Development**  
**John Higgins - Service Manager, Safeguarding Adults, Social Care, Health & Housing**  
**Sharon Daye - Director of Public Health, LBH**

### **Health representatives**

**Maria O'Brien - Divisional Director of Operations, CNWL NHS Foundation Trust**  
**Theresa Murphy - Director of Nursing and Patient Experience, Hillingdon Hospital Trust**  
**Chelvi Kukendra - Designated Doctor, CCG**  
**Jenny Reid - Designated Nurse, CCG**  
**Ceri Jacob - CCG Executive Lead**  
**Reva Gudi - CCG GP Lead**

### **Police and probation representatives**

**Richard Turner - Detective Chief Inspector, Hillingdon Borough Police**  
**Coretta Hine - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police**  
**Paul Granahan - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police**  
**Adela Kacsprzak – Senior Probation Officer, London Probation**

**Niamh Farren, CRC**

**School representatives**

**Sue Pryor - Head teacher, Swakeleys School/Kim Rowe – Head teacher, Bishopshalt School**

**Catherine Moss - Head teacher, St Bernadette's School**

**Representative for special schools – not in post**

**Other representatives**

**Gavin Hughes - Deputy Principal Officer - Uxbridge College**

**Rose Alphonse - Uxbridge College Children's Centre**

**Richard Eason, HAVS**

**Marc Owen, UKBF**

**Graham Hawkes, Healthwatch Hillingdon**

**Lay Members.**

**Rita Payne**

**Michelle Gryc**

## **APPENDIX 2: Glossary**

<b>A&amp;E</b>	Accident and Emergency Services
<b>CAF</b>	Common Assessment Framework
<b>CAIT</b>	Child Abuse Investigation Team (Metropolitan Police)
<b>CAFCASS</b>	Children and Family Court Advisory and Support Service
<b>CAMHS</b>	Child and Adolescent Mental Health Service
<b>CDOP</b>	Child Death Overview Panel
<b>CRC</b>	Community Rehabilitation Company
<b>CSE</b>	Child Sexual Exploitation
<b>CNWL</b>	Central and North West London Trust
<b>CIN</b>	Children in Need (sec 17 Children Act)
<b>CP</b>	Child Protection
<b>DCS</b>	Director of Children's Services
<b>DfE</b>	Department of Education
<b>DPH</b>	Director of Public Health
<b>GP</b>	General Practitioner
<b>HASH</b>	Hillingdon Association of Secondary Heads
<b>HCFTB</b>	Hillingdon Children and Families Trust Board
<b>HCH</b>	Hillingdon Community Health
<b>HMIP</b>	Her Majesty's Inspector of Prisons
<b>ICT</b>	Information and Communication Technology
<b>IDVA</b>	Independent Domestic Violence Advocate
<b>ISA</b>	Independent Safeguarding Authority
<b>JSNA</b>	Joint Strategic Needs Analysis
<b>LADO</b>	Local Authority Designated Officer (allegations against staff)
<b>LAC</b>	Looked After Children

<b>LSCB</b>	Local Safeguarding Children Board
<b>LSP</b>	Local Strategic Partnership
<b>MASH</b>	Multi-Agency Safeguarding Hub
<b>NOMS</b>	National Offender Management Service
<b>NSPCC</b>	National Society for Prevention of Cruelty to Children
<b>NPIA</b>	National Policing Improvement Agency
<b>PIP</b>	Partnership Improvement Plan
<b>POC</b>	Policy Overview Committee
<b>PCT</b>	Primary Care Trust
<b>PEECS</b>	Planning, Environmental, Education Community Services
<b>SAPB</b>	Safer Adults Partnership Board
<b>SCIE</b>	Social Care Institute for Excellence
<b>SCR</b>	Serious Case Review
<b>SEN</b>	Special Educational Need
<b>SIT</b>	Safeguarding Improvement Team (NHS London)
<b>SOS</b>	Signs of Safety
<b>THH</b>	The Hillingdon Hospital
<b>YOS</b>	Youth Offending Service
<b>UKBA</b>	United Kingdom Border Agency

## APPENDIX 3: LSCB Budget

### Income 2013-14

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

### Outgoings 2013-14

Staffing	96,907
Non-staffing	83,935
Chair	24,000
E-learning	9,000
Central Costs	20,200
Catering	1,000
TOTAL	235,042

**Deficit 63,227**

Nb: This identified deficit includes some SCR activity

## **APPENDIX 4: PERFORMANCE DATA**

### **Police Performance:**

In 2013-14 Northwood CAIT improved its performance against SCO5 detection targets as shown below:

	May '13	Apr '14	SCO5 Target
Overall detection rate	11.5%	23.08%	22%
Rape	16.7%	39.5%	22%
Serious Sex Offences	12.5%	36.8%	22%
Violence with injury	6.7%	20.7%	34%

Northwood CAIT serves Ealing and Hillingdon Boroughs. The statistics shown indicate CAIT performance over both Boroughs.

The performance objective for the current year is to improve on 2013-14 detections. The challenge is to achieve this alongside a 20% reduction in costs over 4 years.

Hillingdon Borough Police have provided the following performance figures in respect of children and young people under the age of 18:

From 1 April 2013 until 31 March 2014 there was a total of 1822 victims in the Borough (126 fewer than the previous year) whereby they have been shown as vulnerable for being 17 or under. (under 18). If informants and Witnesses are counted in the figures then this figure goes up to 2325.

### **2013/2014**

APRIL - 140

MAY - 174

JUN - 138

JUL - 156

AUG - 119

SEP - 144

OCT - 182

NOV - 135

DEC - 152

JAN - 155  
FEB - 139  
MAR - 188

**TOTAL 1822**

The **Multi Agency Safeguarding Hub (MASH)** now based at the Civic Centre has superseded the MPS, Public Protection Desk. Statistics recorded during the year for Pre Assessment Checklists/Pre birth PACS in total 5894 , (1,486 more than the previous year).

April 2013	399 Pacs	+	44 Adult reports
May 2013	438	+	30
June2013	389	+	60
July 2013	428	+	50
Aug 2013	316	+	63
Sept2013	388	+	63
Oct 2013	440	+	107
Nov 2013	395	+	105
Dec2013	400	+	108
Jan 2014	426	+	99
Feb 2014	385	+	120
March 2014	480	+	161

These figures show a significant increase in both Pacs for children and Vulnerable adults coming to notice, which is continuing into the new financial year as shown below.

April 2014	489	+	147 Adults
May 2014	498	+	171
June 2014	480	+	169
July 2014	535	+	154
Aug 2014	420	+	185

Additionally these figures do not account for the extra work involved in the MASH process that has been taking place since September 13 when police began working at the civic centre.



Hillingdon MASH deal with Heathrow reports as they do not have a PPD/MASH.

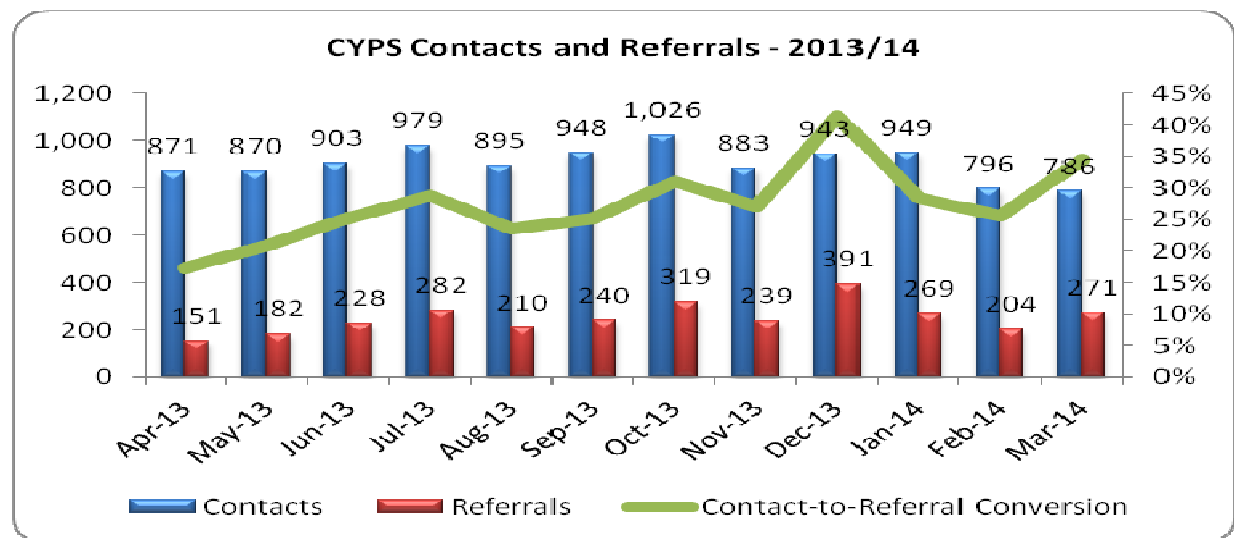
Unfortunately within Merlin separation of these figures cannot be achieved to ascertain the percentage of reports that are generated from the airport because all reports default to XH MASH/PPD.

However they are included in Hillingdon's figures and they are significantly increasing as counter terrorism operations/ FGM operations (Violet) and the roll out of the Vulnerable Assessment Framework takes place.

## Child Protection and Partnership Performance Data:

### Contacts and Referrals

There were 887 contacts to Children's Social Care in April 2014. The number of referrals was 265 giving a contact-to-referral conversion rate of 30% for the month. The table below shows a steady increase over the year 2013/4.



The table below provides a comparison of 2013/14 data with the previous year.

CYPS Contact and Referrals 2013/14			
	2013/14	2012/13	Variance
Number of Contacts	10849	12145	-11%
Number of Referrals	2986	3176	-6%
Contact to Referral Ratio	28%	26%	
Number of NFA	7863	8969	-12%
Contact to NFA Ratio	72%	74%	

There was a small decrease in contacts and referrals compared to last year. A shared understanding of thresholds from partner agencies as well as social

work staff is central in ensuring that appropriate contacts are progressed by social care.

Implementation of effective early intervention systems may lower demand around statutory services. Early intervention work is currently being delivered through the Family Key Working Service.

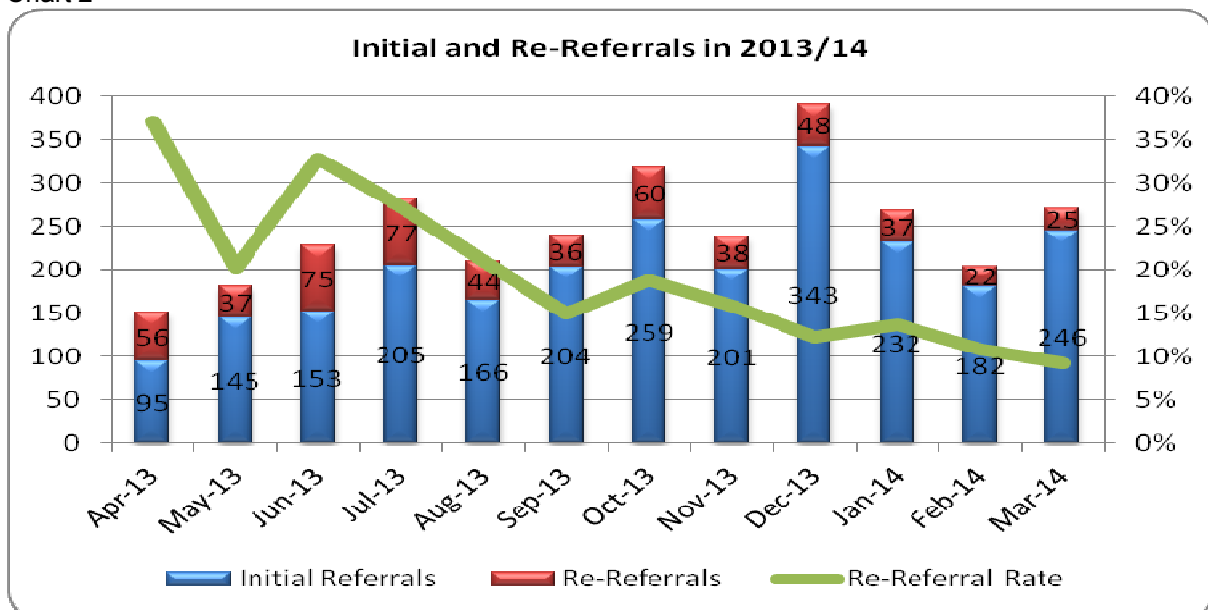
### Re-Referral Rate

The table below shows the change in re-referral numbers for the last two years.

CYPS Re-Referrals 2013/14			
	2013/14	2012/13	Variance
Number of Re-Referrals	555	750	-26%
RE-Referral Rate	19%	24%	-5%

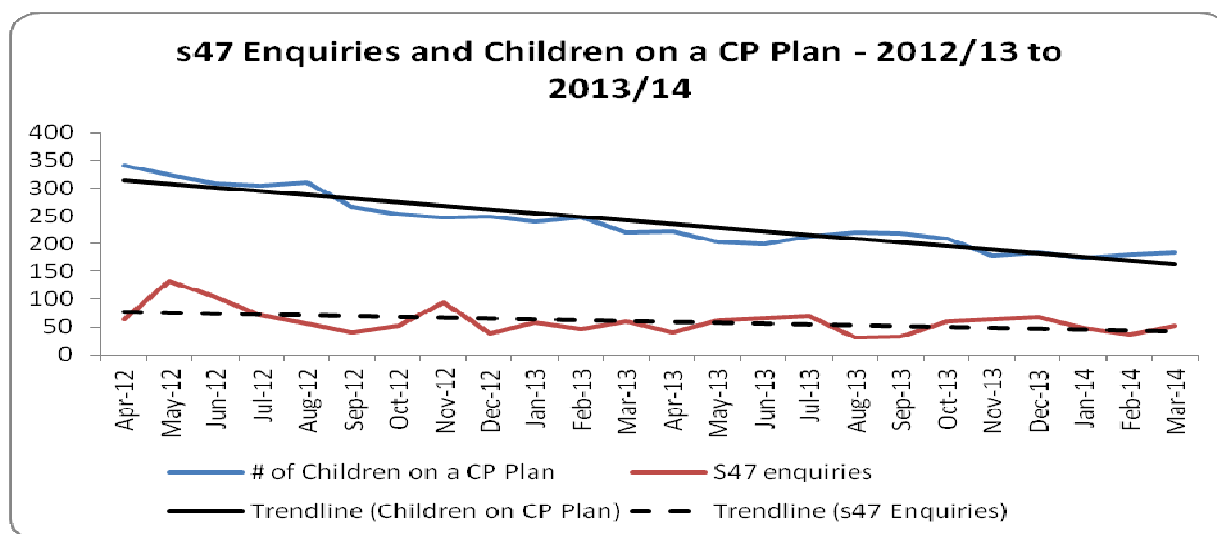
The fall in the number of re-referrals over the last twelve months is positive and may indicate that decision-making and thorough completion of tasks has improved.

Chart 2



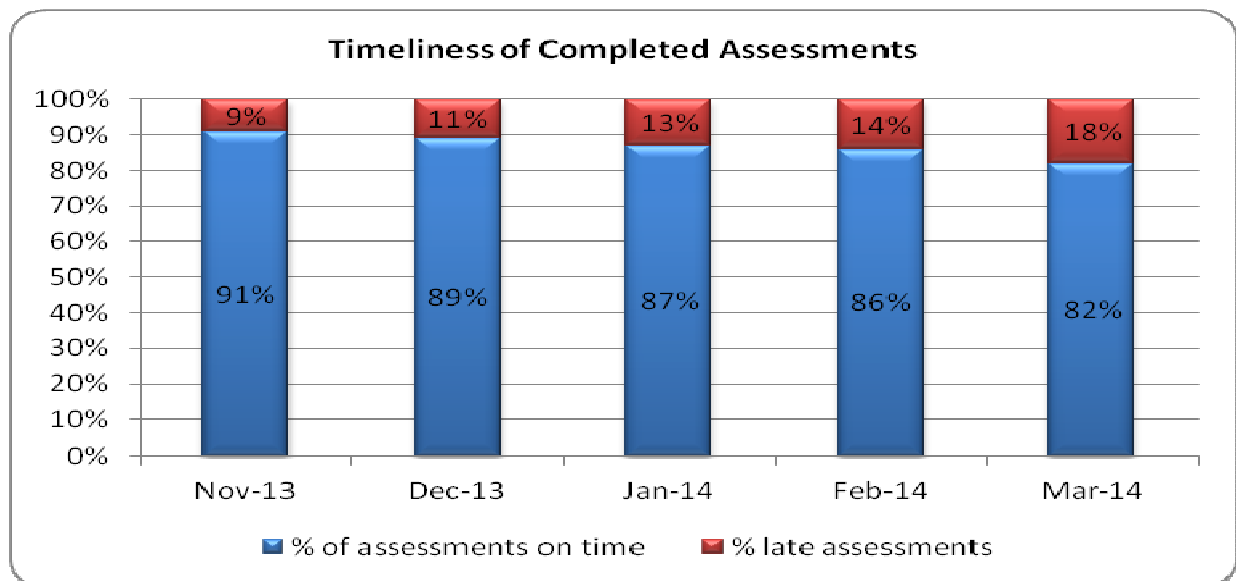
The 2014/15 target re-referral rate has been set at 15%.

## Child Protection



A broad ratio of s47-to-ICPC can be calculated to show conversion rates for the last two years:

<b>SECTION 47 PROGRESS</b>			
	<b>2012/13</b>	<b>2013/14</b>	<b>Variance</b>
<b>S47 Enquires</b>	816	630	-23%
<b>Number of ICPC</b>	241	245	+2%
<b>S47 to ICPC Ratio</b>	30%	39%	+9%
<b>Number of NFA's</b>	575	385	-33%
<b>S47 to NFA Ratio</b>	70%	61%	-9%



### Partnership Data

A&E data below has been provided by the Hillingdon Hospitals NHS Foundation Trust.

<b>A&amp;E DATA – Children under 18 years of age</b>				
	2012/13		2013/14	
	Number Presenting	Number Admitted	Number Presenting	Number Admitted
<b>Alcohol Intoxication</b>	29	6	33	2
<b>Mental Health</b>	52	11	41	4
<b>Self Harm</b>	10	6	13	1
<b>Substance Misuse</b>	14	0	6	3
<b>Overdose</b>	96	23	71	9

### Workforce Data

The following table shows vacancy rates using data from Hillingdon's HR system and information provided by the NHS.

<b>WORKFORCE VACANCY RATES</b>		
	2012/13	2013/14
<b>Children's Social workers – HCPC registered inc. Managers &amp; Service Managers</b>	19%	32%
<b>Nurses (Paediatrics)</b>	10%	5%
<b>Midwives (Maternity)</b>	2%	2%
<b>Nurses (A&amp;E)</b>	11%	20%
<b>Health Visitors</b>	7%	13% (Q3)

As reported in June 2014, there are 175 qualified social worker posts (HCPC) within CYPS with 109 (62%) of these filled permanently. Of the 66 vacant posts, 59 are filled by agency workers.

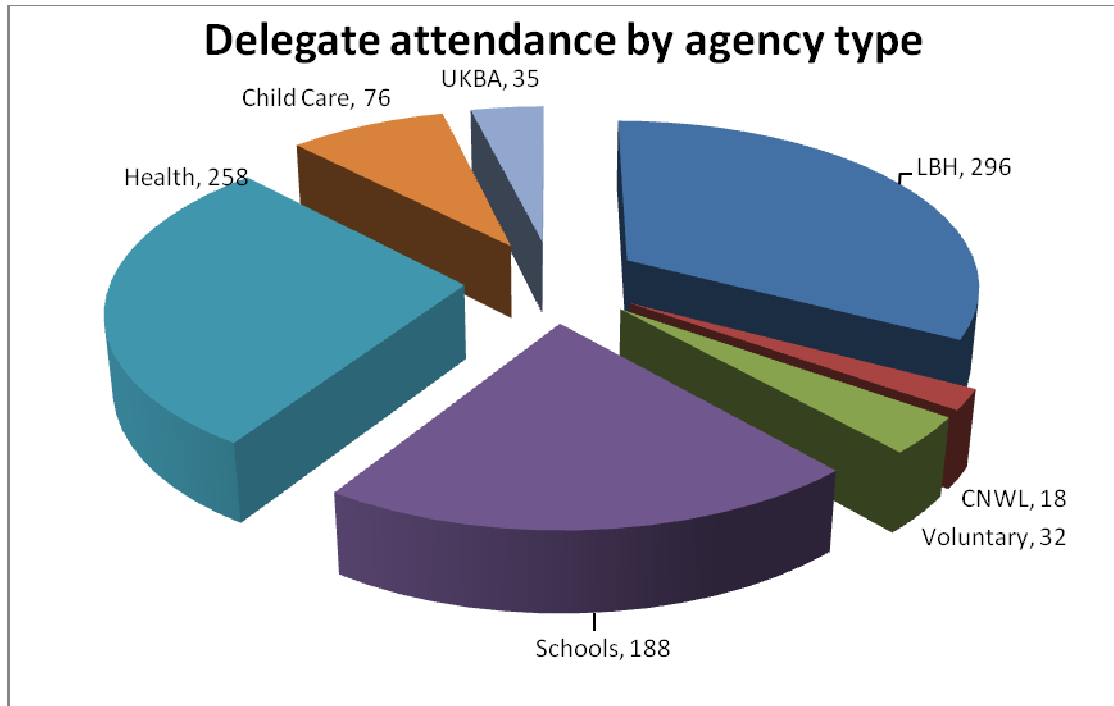
Recruitment issues continue to challenge the stabilisation of the workforce with feedback from other London Boroughs suggesting that recruitment and retention of experienced social workers, particularly in the child protection, is proving challenging.

## Learning and Development.

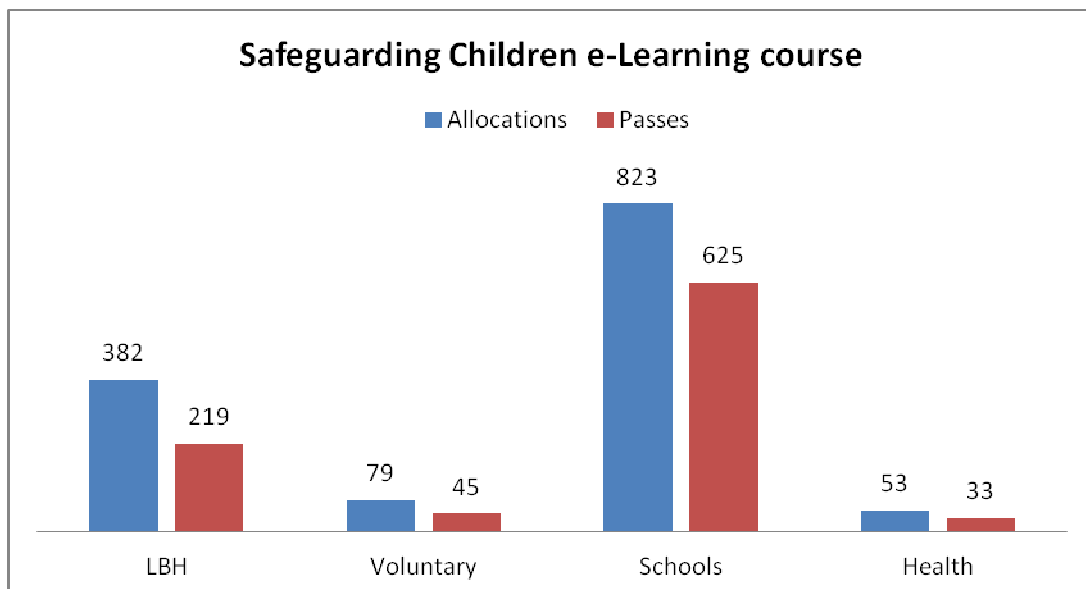
### Classroom based learning

The chart below shows the percentage attendance by agency type and we can see that the greatest users of the programme are Schools (including FE Colleges), Health (including hospital staff) and the Local Authority.

Working Together to Safeguard Children	176	£0
Refresher Working Together	207	£0
Core Group Training	29	£0
Child Trafficking	61	£3,200
Domestic Violence - Impact on Children	28	£0
Awareness of Emotional Abuse	36	£0
Multi Agency Safeguarding Hub - Awareness	96	£0
Signs of Safety Methodology Training	270	£20,459
<b>Grand total</b>	<b>903</b>	<b>£23,659.00</b>



The chart below illustrates the usages of this e-Learning module by agency type

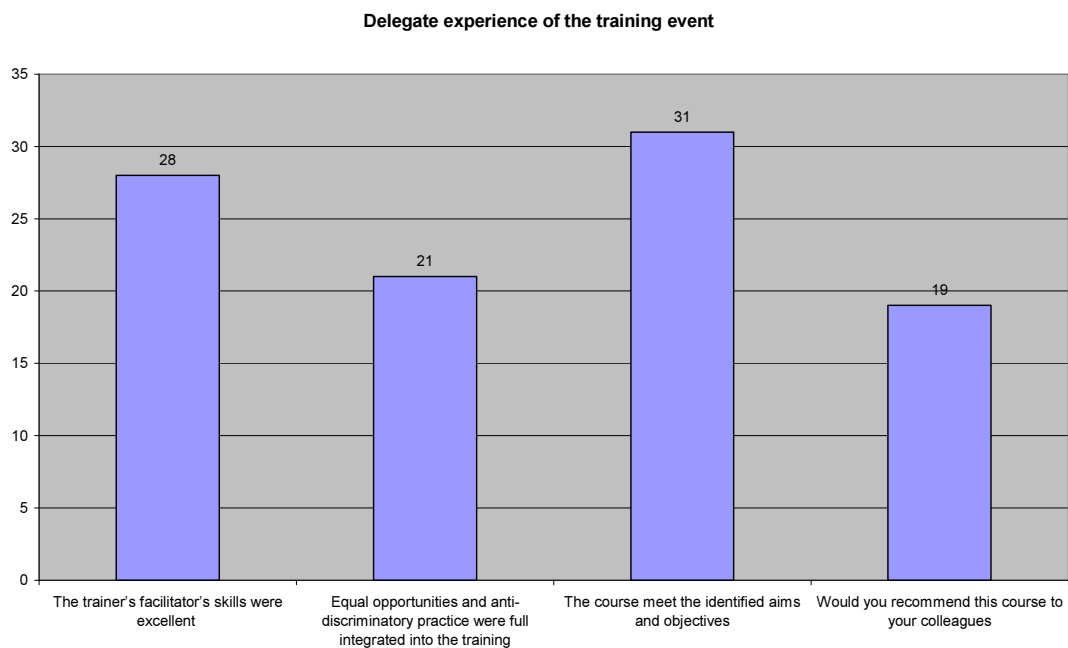


The table below gives the number of delegate places used by each agency type and the percentage of delegate places used overall for the year 2013-2014.

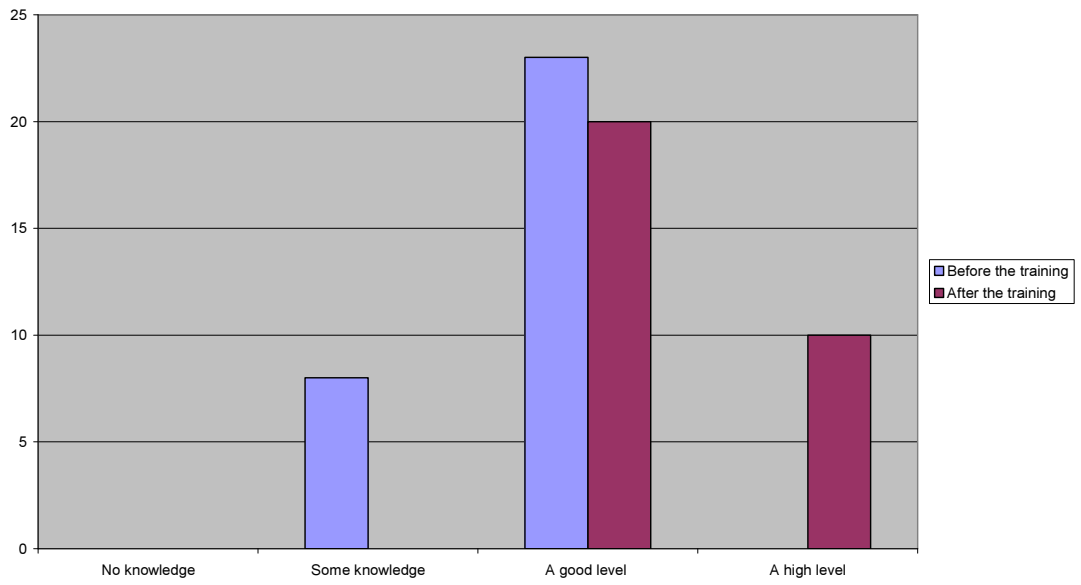
Training Method	Schools	Local Authority	Health	Other**
Classroom delivery	188	296	258	161
e-Learning	625	237	34	47
Total	813	533	292	208
% Use of total training on offer	44.04%	28.87%	15.82%	11.27%

\*\* =Voluntary Sector / Child Minders / UKBA etc..

The LSCB undertook a pilot within the year to evaluate the impact of training, the following tables illustrate the feedback.



**Delegates knowledge before and after training**



**Delegates rate of practice confidence before and after training**

