Children Missing from Education in Nottingham

A report to

Nottingham City Council's CME Team.

Nottingham Business School,

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Contents

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The team would like to express thanks to the Nottingham City Council CME team for their help and assistance with this project. We would wish to acknowledge the assistance of James MacLean and Wayne Smith who acted as both sponsors and the key source of data and advice for this project. Any errors or omissions are the responsibility of the authors.

Children Missing from Education in Nottingham

Executive Summary

In a recent report the Local Government Association found that "there is a distinct paucity of any comprehensive, reliable data outlining the numbers of children who are missing extended periods of formal, full-time education" (LGA 2020 p1). Without a clear sense of how many children in England might be missing out on their entitlement to a formal full-time education it is very difficult to be precise about the scale or nature of intervention that might be needed either locally or nationally to address the issue. This report starts to address that information deficit for the City of Nottingham.

Children missing education are difficult to identify; are from heterogenous backgrounds and are often vulnerable with complex social, behavioural, educational, medical, or mental health needs. Section 436A of the Education Act 1996, places a duty on the local authority to identify children of compulsory school age in their area who are not registered pupils at a school and are not receiving suitable education other than at a school. This project investigated the experience of the CME Team in the City Council using the databases available to the team for the period 2016-2021.

The study first looked at the geographical and demographical pattern of CME cases in Nottingham. It found a remarkably stable in-year pattern of cases notified to the team (particularly during the 'transition' period each year in the month of September) but a smoother in-year pattern for their resolution. The CME team works to resolve the cases continuously throughout the year regardless of whether there has been an influx of cases or a dip in referrals in a particular month.

Geographically the study found three 'tiers' of CME cases with two areas (NG7 and NG8) each accounting for more than 20% of cases; four postcodes (NG2, NG3, NG5, and NG6) accounting for more than 10% and the remaining postcodes all having less than 3%. We briefly explored whether this might be related to housing tenure as NG7 and NG8 contain a high percentage of rentable properties as indicated by the councils' 'Estates Lettings Areas' records, and recent changing patterns of migration and/or historical and more stable patterns of multiple-deprivation in the city.

While the pattern relating to the multiply deprived areas was not a surprising finding, it reinforces the fact that children living in the most deprived households are the ones who most need to be in education but are also the most likely to have children missing from education. The study found similar but different patterns of cases for the 5-9-year age groups (primary school age children) than 10–14-year age groups (secondary school age children).

The study also analysed the characteristics of CME Cases in Nottingham City. It found a fairly stable pattern over time, with little difference in their distribution by gender and a 'bell shaped' distribution in relation to the year of the national curriculum reaching a peak in Year 7 (11.7%) with relatively high percentages between Year 5 to Year 8.

When examining the distribution of the CME cases among different ethnicity groups, the study found that 40% of the CME cases fell into the category of *Information not yet obtained* and when compared to the results of the School Census in 2021, the gap was substantial. More research and information is needed to understand the reasons and barriers to obtaining children's ethnicities from the families of CMEs, but this lay outside of the scope of the project.

The study also looked briefly at the origin of referrals by type of school and by academies in particular (as the predominant provider in the city). This showed the CME team has established good working relationships with all types of schools, with internal council teams, with wider NCC partners and agencies as well as with external partners most notably other local authorities providing similar services. This level and quality of collaborative working is essential to providing an economic efficient and effective service to both the council and to the clients of the service.

The study also looked at case outcomes both in terms of the process and in terms of the success in resolving cases. The study looked at 5615 cases and found that 71% of the cases had been resolved by the CME team, with 29% open ongoing cases. Between 2016 and 2018 there was a steady increase in the percentage of cases with the outcome *returned to education* and then a dip in 2020 and an upturn in 2021 to 59%. The trend for *case closed* remained steady from 2016 to 2018 but declined in 2019 and then sharply increased to 39.2% in 2020 and back down to 25.7% in 2021.

The time it takes for the CME team to resolve a case, was extremely varied. Some cases could be resolved on the same day as when the CME team started the investigation, but in contrast, it took 2307 days (more than 6 years) to solve one extreme case. The study found the percentages for resolved case gradually decreased and the percentages for open case gradually increased over time. In 2021, more than half of cases were resolved and this included 44% that were the accumulations of previous unsolved cases. As almost a quarter of the cases were resolved within 7 days, the study investigated what kinds of outcomes were achieved by acting promptly and compared the response to cases in the most deprived areas in comparison to less deprived areas. We found almost no difference in these outcomes.

The findings relating to the CME workforce reveal that the team works on a very clearly defined on-going task but also highlights and emphasises the importance of local knowledge and experience in this area of work and the importance of the often 'hidden' skills of trust, reciprocity, perseverance, diligence, and empathy with clients that are essential for the efficient and effective delivery of the service.

The study undertook two simple regression analysis, (specifically using the binary logistic model), to help enhance the understanding of the relationships between whether cases were solved or unsolved; and how long it took if the case was solved using variables, such as gender, type of education, ethnicity, location and deprivation. There was no difference between male and female cases with regards to case length. Cases from secondary schools take almost 27 days longer on average to solve when compared to cases from primary schools.

Knowledge of ethnicity is however significant as when compared to having no information on ethnic background, cases where the student is White, Asian, Mixed, or Black take fewer days

to resolve. Finally, we found that deprivation doesn't appear to affect the length of time required to solve cases. The study found that not only was the likelihood of an unsolved case with ethnicity information (White, Asian, Mixed, or Black background) lower than a case without the ethnicity information, but it also took fewer days for the CME team to resolve the case when the ethnicity information was provided. This might appear obvious, but it does re-emphasise the importance of obtaining ethnicity information for CME cases.

Finally, we suggest that to significantly advance the strategic knowledge and understanding of the service both in the city and more widely, the team should consider undertaking some comparative work with the CME services teams in other local authorities.

1. Introduction, background, and research methods

In collaboration with the Children Missing from Education Team, at Nottingham City Council (CME, NCC), this project aims to examine the situation with regard to "children missing education" in the city between 2016 and 2021. In their recent report on the national picture, the Local Government Association found that "there is a distinct paucity of any comprehensive, reliable data outlining the numbers of children who are missing extended periods of formal, full-time education" (LGA 2019 p1). Without a clear sense of how many children in England might be missing out on their entitlement to a formal full-time education it is very difficult to be precise about the scale or nature of intervention that might be needed either locally or nationally to address the issue.

This report starts to address that information deficit for the CME team and the city. In so doing it also highlights a number of areas where further research or inquiry might assist the CME team in further understanding the situation in the city. However there remains an issue regarding the lack of the comparable CME data available at the local authority level for benchmarking and comparative research to enable the sharing of good practice.

The report is also intended to contribute to the CME teams preparations for a forthcoming Ofsted Inspection of the service and to assist resource allocation and future workforce planning in the light of the pandemic.

1.1 Background

Section 436A of the Education Act 1996, places a duty on the local authority to identify children of compulsory school age in their area who are not registered pupils at a school and are not receiving suitable education other than at a school. Previous (Pre-COVID) studies (May-Chahal & Broadhurst 2006, Botham 2011, LGA 2020) have shown that children missing education are difficult to identify; are not from homogenous backgrounds and are often vulnerable with complex social, behavioural, educational, medical, or mental health needs. Ofsted (2013) have previously reported that many local authorities had little understanding of how much education vulnerable children with complex needs actually received, and many failed to arrange suitable education, monitor the effectiveness of their education, collect relevant information and analyse this to gain knowledge and understanding of this group of children in pursuance of the direct, institutional and statutory duty of care. Consequently, there are potentially serious implications for the safeguarding of these children and a danger of them becoming 'invisible' or slipping under the local authorities' radar (Children's Commissioner 2019).

There is a growing concern that the number of children missing education in Nottingham is increasing and that this is being exacerbated by the pandemic. This reflects similar concerns from the Local Government Association findings (2020) which reported an increasing number of children missing formal, full-time education nationally. Although, NCC has the

responsibility to ensure school age children receive suitable education, the capacity to carry out its duty at a detailed and lengthy individual case level is extremely challenging.

This project investigated the local experience of the CME Team in the City Council. It examined the current and past record of CME in the City for the purposes of:

- Understanding the changing demographic of the CME group.
- Understanding the changing characteristics of the CME group.
- Identifying the main patterns and 'triggers' that have resulted in referrals of CMEs from schools and elsewhere to the service
- Identifying the determinants of whether a CME case is resolved, and how long it takes if it has been resolved.

1.2 Research Design and Method

Building on a short literature review of the guidance, policies, and practice relating to CME, and adopting a quantitative research approach, utilizing existing data extracted from the databases compiled and used by the CME team in Nottingham City Council, this project examined and analysed:

- The demographic of the CME group including its distribution across the city, level of deprivation, gender, national curriculum year group, and ethnicity.
- Trends and changes within the demographic over a 6-year period.
- Trends within the CME workload (number of cases, days taken to resolve cases, patterns, and trigger points to referral from schools' overtime).
- The relationships between whether a CME case is unsolved and how long it took if it has been solved against factors, such as gender, type of education, ethnicity, location and deprivation.

Additional data relating to the populations in different age groups, the index of multiple deprivation data for the city and pupils' ethnicity data from the school census at local authority level were also applied to enable meaningful comparisons.

This data was supplemented by qualitive information from 5 meetings with the CME team and examination of notes from previous team meetings.

1.3 Statistical Methods

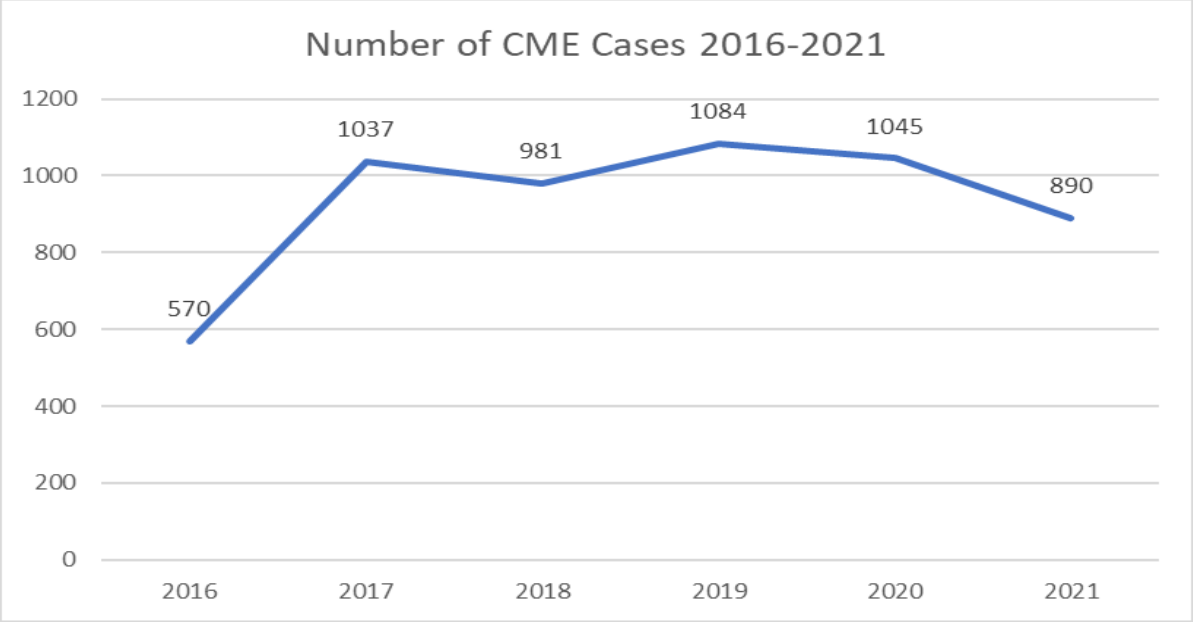
The data were analysed with the use of MS Excel, the Statistical Package for the Social Sciences (SPSS), and Stata. We first applied the descriptive statistics and inferential statistical methods, and these facilitated some binary logistic regression analysis to be performed.

With the assistance of the Geographical Information System at the council we were able to identify the locations of the CME within the NCC boundary. This information has been mapped and is presented in the PDF version in this report. The following sections present the results of the descriptive and inferential statistics and analysis.

2. Geographical and demographical analysis of CME cases in Nottingham

2.1 CME Cases per year within Nottingham City Council boundary

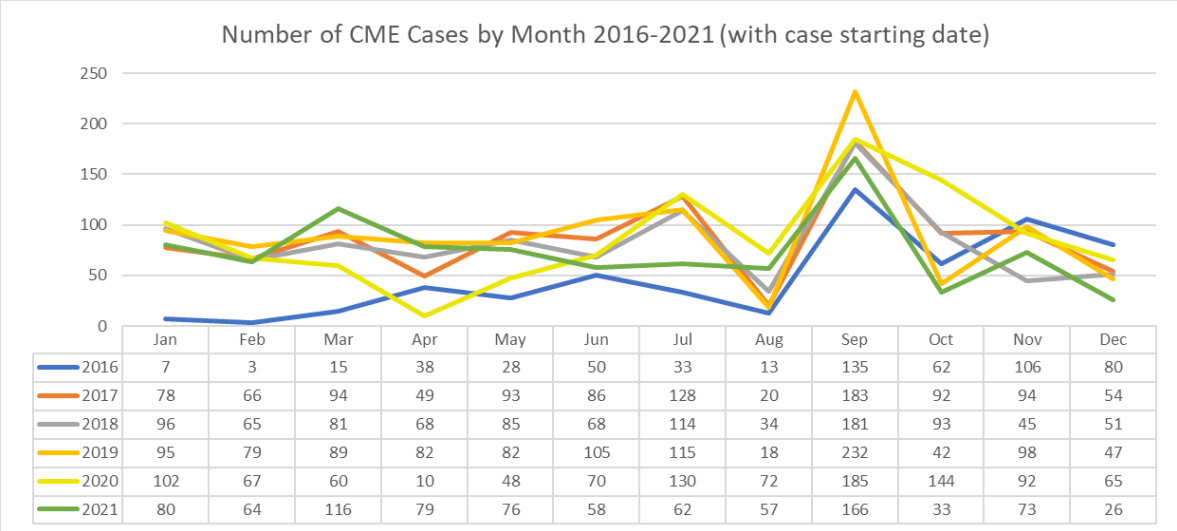
Figure 1: Number of CME Cases per year in Nottingham City 2016-2021



In total, there were 5,607 CME cases from 2016 to 2021 within Nottingham City that were analysed in this project. Overall, Figure 1 shows a sharp increase in numbers between 2016 and 2017 and that since 2017 there has been around 1000 cases per year on average from 2017 to 2021.

2.2 CME Cases per month

Figure 2: Number of CME Cases by Month (by case starting date) 2016-2021



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	7	3	15	38	28	50	33	13	135	62	106	80
2017	78	66	94	49	93	86	128	20	183	92	94	54
2018	96	65	81	68	85	68	114	34	181	93	45	51
2019	95	79	89	82	82	105	115	18	232	42	98	47
2020	102	67	60	10	48	70	130	72	185	144	92	65
2021	80	64	116	79	76	58	62	57	166	33	73	26

Examining in-year profile of CME cases by month, Figure 2 shows the in-year trends of cases by looking at the cases from their starting date in each year. Consistently, all years revealed a sharp increase in the month of September which represents approximately 20% (on average) of the cases within the year. The second highest peaks were in July and November, which each represent approximately 10% (on average) of the cases within the year. The next highest peak was in March which represented around 8% of the cases within the year.

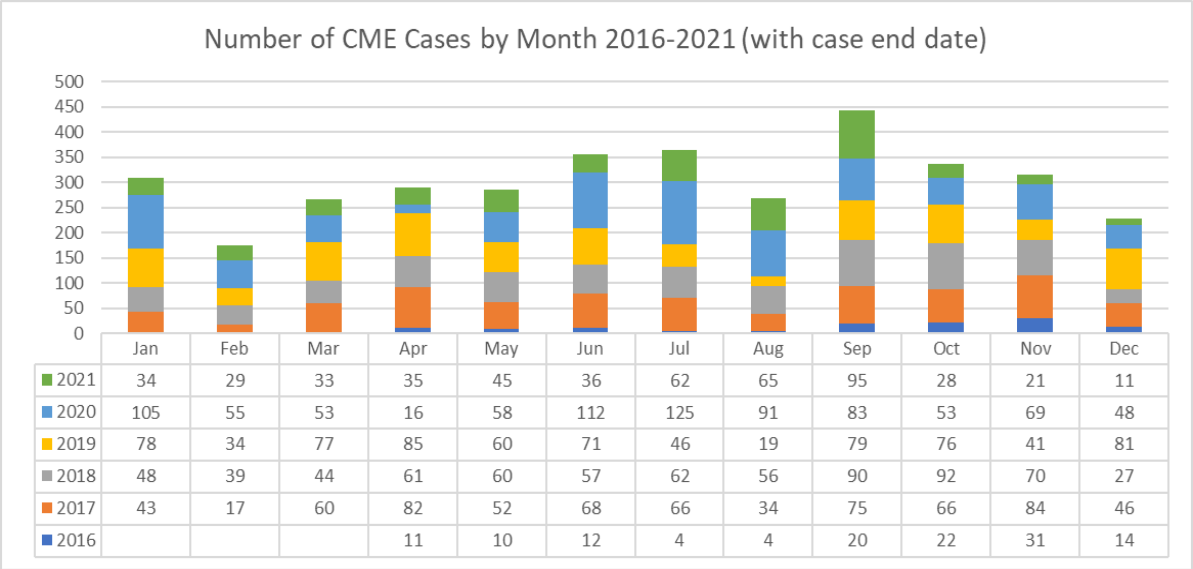
The sharp rise in September is associated with the fact that typically September is a transition period within the school year, a critical time when schools return after the summer break, especially for pupils moving from primary school (year 6) to secondary school (year 7). It is a time when all the children come back to school, rather than the occasional child going missing and partially accounts for so many places being referred to CME in September.

Absence may be due to families still being on holiday or, in more recent times, being 'stuck' abroad and not being able to travel back easily for a variety of reasons. Schools, most of which are over-subscribed in Nottingham, are anxious to fill places where pupils have failed to return after the summer break so tend to be quicker at referring CMEs during this time too.

It might be a 'water-shed' moment when parents make decisions about their child's future and decide to move elsewhere at a convenient time, educationally. So, it could be due to parents applying for more than one school in different authorities, having offers from more than one school, accepting one offer but not informing anyone about the offer they didn't take up.

Any child who has a start date, which has been agreed by the admission authority and parent, is legally on the 'roll' from that start date whether they actually turn up for school on the first day or not. Therefore, for a school to take a child off the roll, assuming they don't know where the child is, the local authority, via the CME team has to make investigations prior to the school considering whether to take that child off roll or not. This may encourage schools to complete referrals at this stage.

Figure 3: Number of CME Cases by Month 2016-2021 (with case end date)



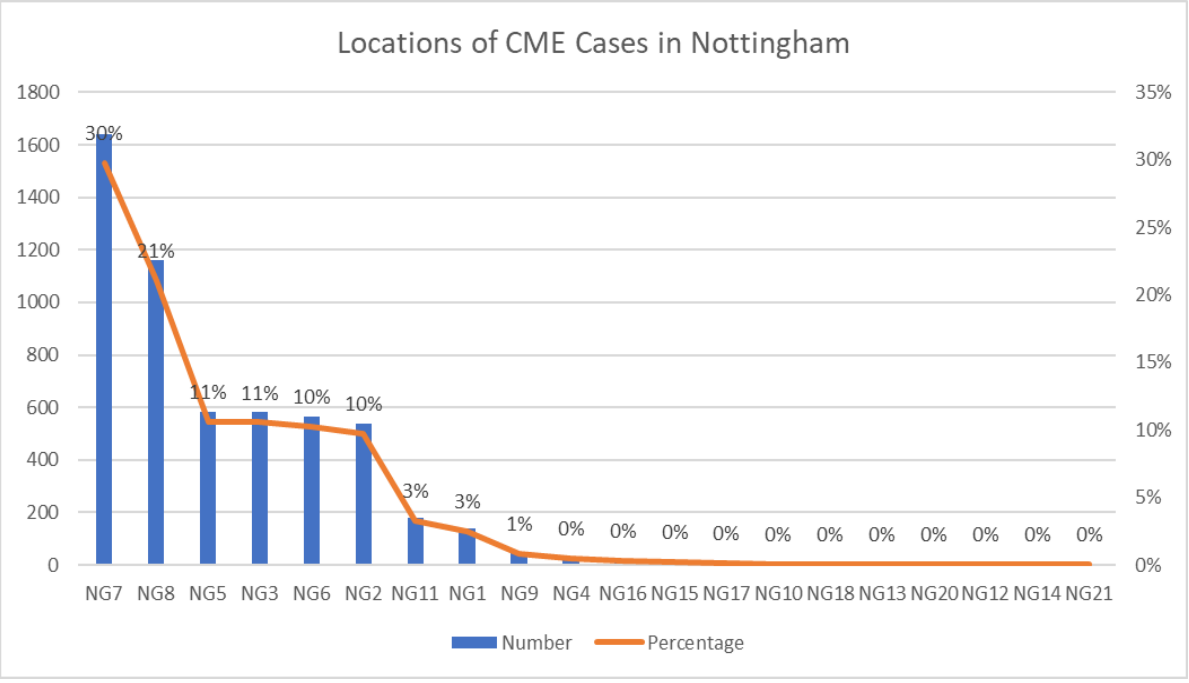
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	34	29	33	35	45	36	62	65	95	28	21	11
2020	105	55	53	16	58	112	125	91	83	53	69	48
2019	78	34	77	85	60	71	46	19	79	76	41	81
2018	48	39	44	61	60	57	62	56	90	92	70	27
2017	43	17	60	82	52	68	66	34	75	66	84	46
2016				11	10	12	4	4	20	22	31	14

This figure examines the number of CME cases by end date (cases resolved by the CME team at NCC), the pattern appears less stark than the pattern associated with starting date shown in Figure 2. Figure 3 shows that the month of September still had the highest number of cases being resolved and hence closed (13% on average), but this followed by June (10%) and July (9%). Overall, the trend for the CME cases being resolved was more even throughout the year.

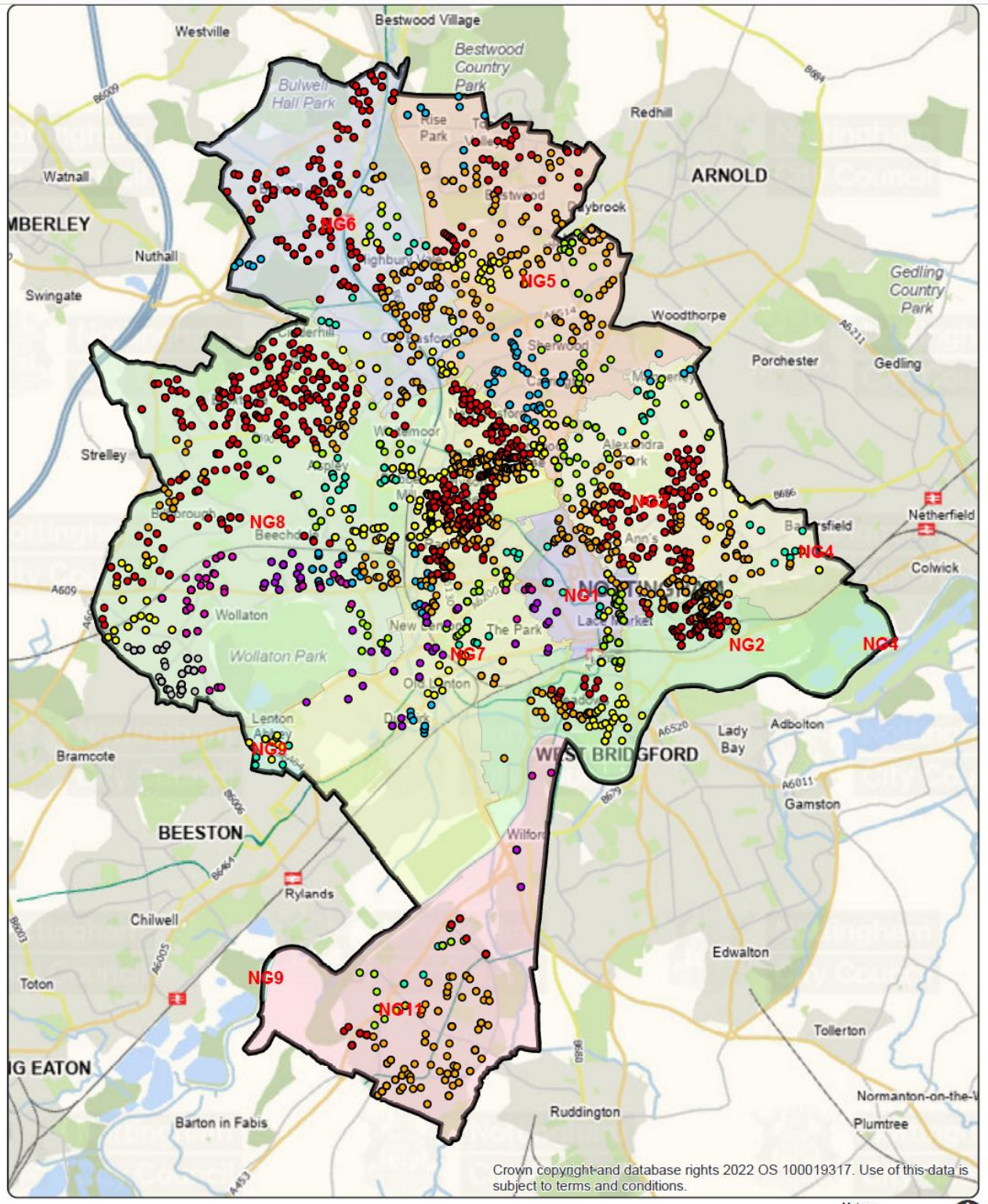
The results indicate that the CME team works to resolve the cases continuously throughout the year regardless of whether there has been an influx of cases or a dip in referrals in a particular month. The cases which have not been solved or closed in the previous year are carried forward to the following year, so it is a continuous stream of work for the CME team as cases are live until they get resolved or the child exceeds the age for compulsory education. The compulsory school leaving age in the UK is 16 (National Curriculum Year 11 henceforth NCY 11) after which they are not the responsibility of the children missing from education team. Children above the compulsory school leaving age are not therefore included in the CME database for this project.

2.3 CME cases by location and levels of deprivation within the city

Figure 4: CME Cases by Locations



Map 1: CME Cases for 2016 - 2021 Showing Deprivation Level



Key

- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- 60.1-70%
- 80.1-90%
- 90.1-100%
- Most deprived 10%

Nottingham City Council

Figure 4 and Map 1 demonstrate where the CME cases were located within the city boundary. Three tiers can be observed from the figures.

Tier 1. More than half of the CME cases are in two postcode areas. 30% of the cases were from the NG7 postcodes (including New Basford, Forest Fields, Hyson Green, Radford, and Lenton) and 21% of the cases were from NG8 postcodes (including Aspley, Wollaton, Whitemoor, and Bilborough.

Tier 2. Four postcodes have between 10% and 11% of cases. These were NG5 (Sherwood, Bestwood, Carrington, Top Valley, and Rise Park), NG3 (Sneinton and St. Anns), NG6 (Bulwell and Old Basford), and NG2 (City centre, Sneinton, and Meadows).

Tier 3. Postcodes have less than 10% of the cases. These are NG11, Clifton area (3%) NG1 mainly within the city centre area (3%), NG9 Lenton (1%), and NG4 Dale (<1%).

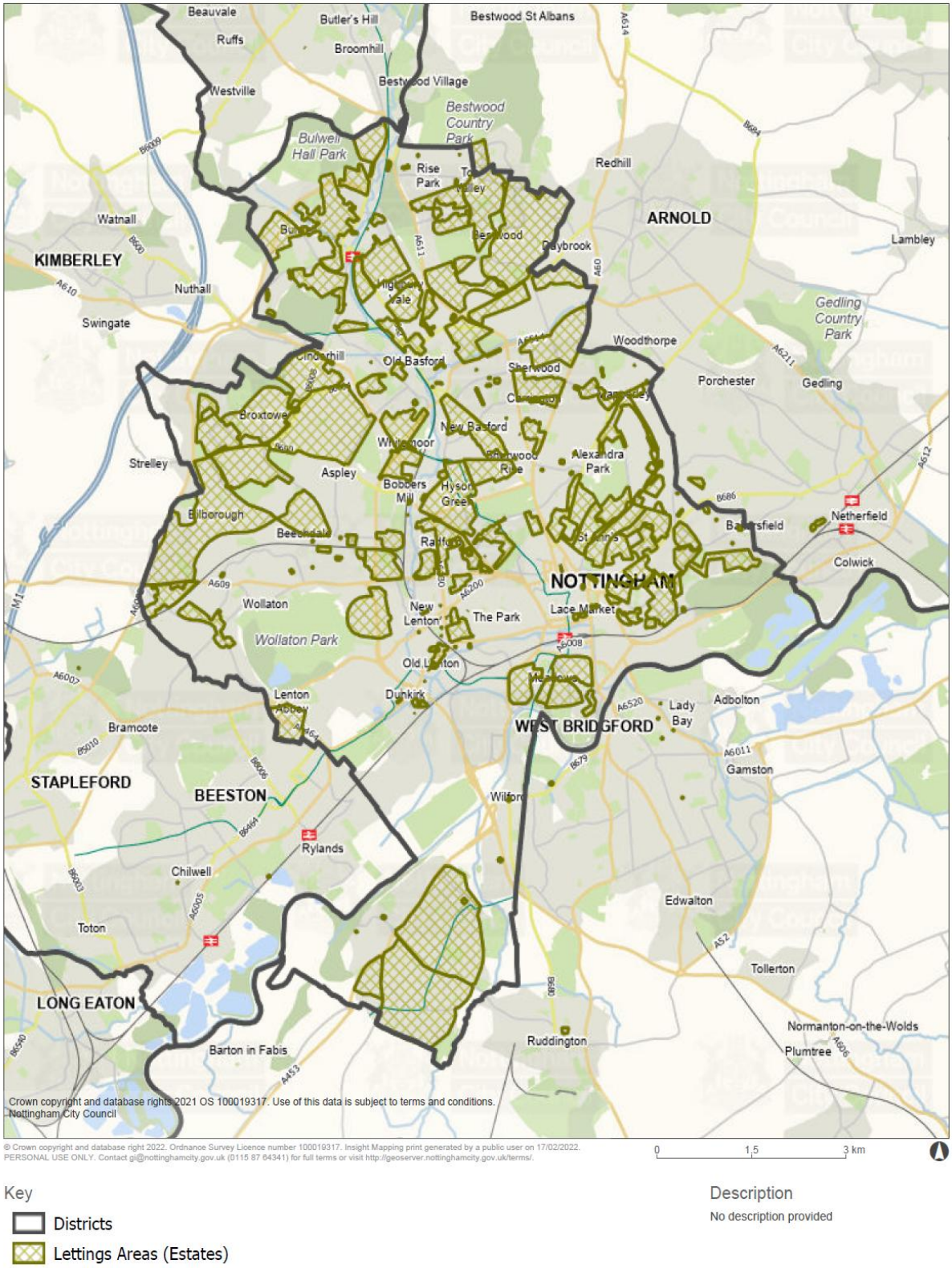
There are a small number of cases from outside of the city boundary mostly from adjoining postcodes adjacent to the boundary (NG16, NG15, NG17, NG10, NG18, NG13, NG20, NG12, NG14, and NG21). Some of these cases may be accounted by either former addresses of cases moving into the city from county addresses or families living in the county, being referred to the city by a city school. In the latter cases these would be sent to Nottinghamshire County Councils CME team to investigate and closed to city CME (so they are only briefly a city CME case, prior to handover).

One factor influencing the tier one areas is that the NG7 and NG8 postcodes contain a high percentage of rentable properties as shown by overlaying the 'Estates Lettings Areas' shown on Map 2, with case locations shown on Map 1. It is highly likely that there will be a relatively high number of families moving in and out of those 'letting' areas and therefore generating cases of children missing education while families were relocating. NG2 was another area (10% of the cases) which had a high percentage of rental accommodations, (although only parts of NG2 i.e. parts of the city centre and the Meadows, fall within the city).

Another factor may be associated with levels of migration. The locations with high percentages of the CME cases historically also had relatively high numbers of people who had migrated from Europe to Nottingham for employment purposes but have since returned to the country of origin (or previous homeland) after the UK left the EU. There were also people from transient communities, (such as Roma and Travellers) within those areas which contributed to the high rates of family movement.

These cases often have logistical, and technical issues, some of which it will be very difficult to address solely by the CME team as there are root causes that require action by other agencies. For example, when a family are likely to be evicted by a registered social housing provider the children's schooling needs should be considered. This may lead to reconsideration of an eviction or, if it's a relocation, then it could be within reach of current school. Similar practices could also be part of processes within social care, the home office and other welfare services.

Map 2: Letting Area in Nottingham City Council



2.4 CME in-year trends by location

Figure 5: Trend of CME Cases by Location for 2016 to 2021

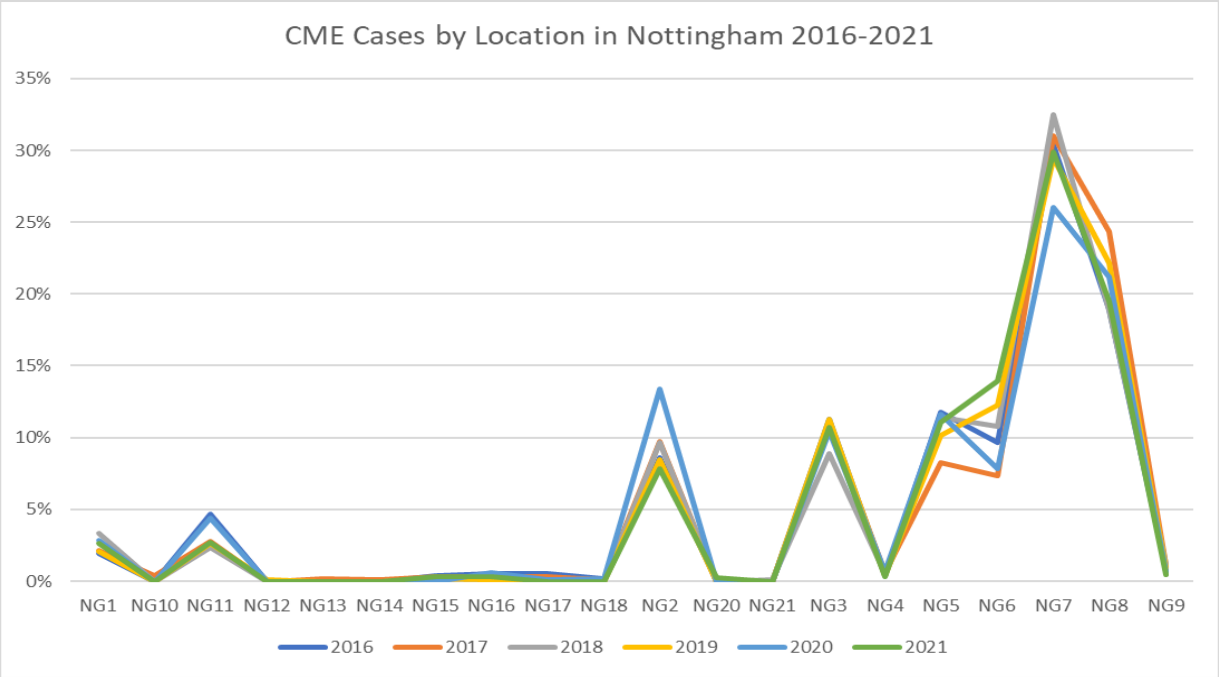


Figure 5 displays the pattern of the CME cases by location for each year (2016-2021) when an extraordinarily consistent pattern has been established in each year. NG7 (26% to 32%) and NG8 (19% to 24%) had the highest percentages of the cases, followed by NG2 (8% to 13%) and NG3 (9% to 11%) with a small percentage of NG11 (2% to 5%).

Figure 6: CME Cases by Location in Nottingham from 2016 to 2021

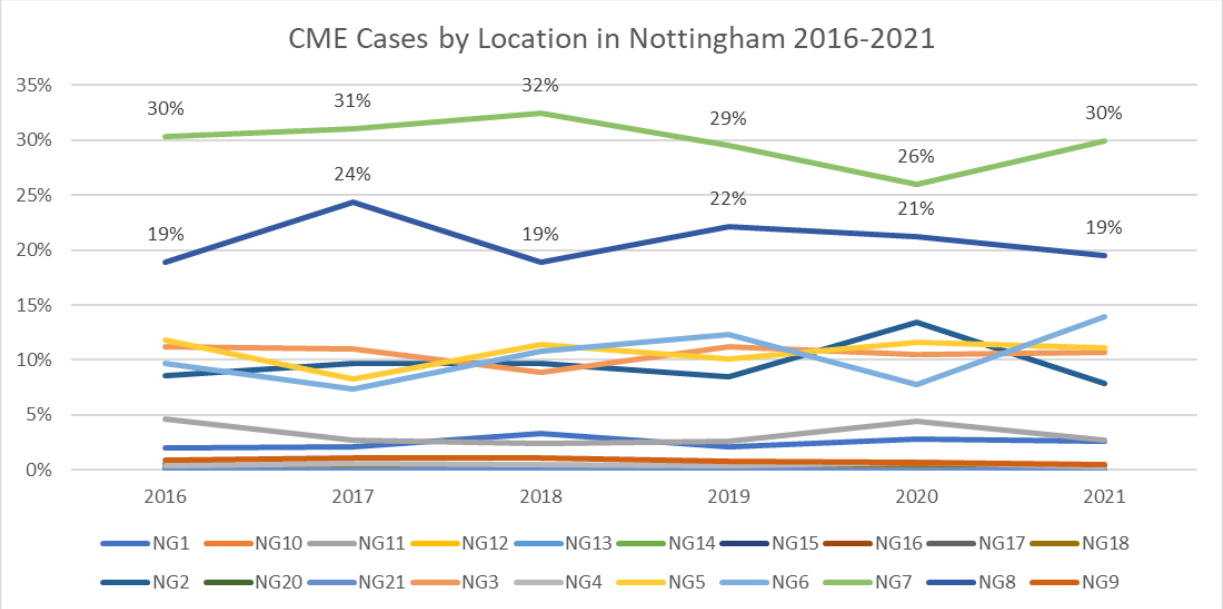


Figure 6 shows the trends in CME cases for each location (by postcode) from 2016 to 2021. Overall, the trend was relatively consistent for all postcode areas throughout 2016 to 2021 with only relatively minor fluctuations over time.

The implications from these very consistent (Figure 5) and relatively consistent patterns (Figure 6) are two-fold. It identifies and potentially predicts the areas where the CME cases are most likely coming from, and it provides the CME team and NCC with relatively robust information in terms of workload planning as to which area that work needs to be focussed upon and which schools or communities to prioritise and/or reassess in their resource deployment. This predictable and stable pattern also provides evidence which could help engage local ward counsellors in resolving CME cases in their areas. It also strengthens the case for maintaining the relatively limited resource of the CME workforce at a time when NCC like all Local Authorities are experiencing financial reductions in central government support.

2.5 CME and areas of multiple deprivation in the city

Historically, Nottingham City is a city with relatively high areas of deprivation when compared to other cities in England and in 2019 'had been named the UK's "poorest city" on a government list - the fifth time in seven years' (BBC News 2019). This is based upon Office for National Statistics (ONS) figures for gross disposable household income (GDHI).

According to the Nottingham Insight Report (2019), Nottingham was ranked nationally as the 15th for the proportion of Lower Super Output Areas[1] (LSOAs) in the most deprived 10% nationally with less disposable household income, high unemployment rate, low educational attainment, and high university student population. Nottingham has a high concentration of its population living within the most deprived 10% areas. Comparing their Average Score, Nottingham was ranked the fourth most deprived of the 9 'Core Cities' behind Liverpool, Manchester and Birmingham in England. Figure 7 shows the percentage of CME cases falling into the areas of the top national decile of the national Index of Multiple Deprivation[2] (IMD) that are within the city boundary i.e. areas that are amongst the 10% of most deprived areas in the country.

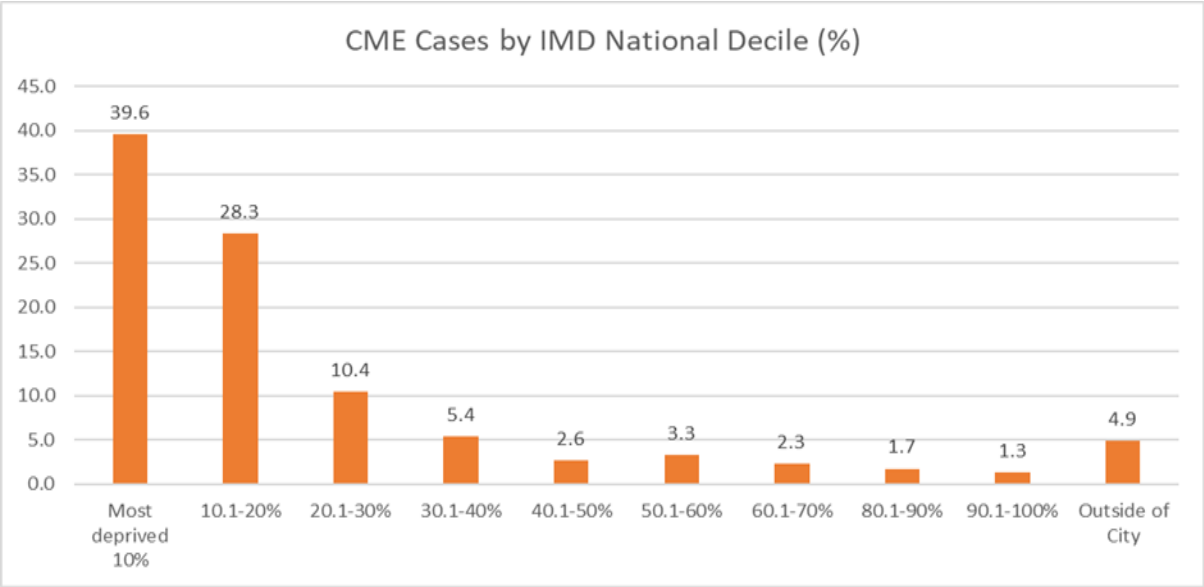
According to the Nottingham Insight Report (2019), Nottingham was ranked nationally as the 15th for the proportion of Lower Super Output Areas[3] (LSOAs) in the most deprived 10% nationally with less disposable household income, high unemployment rate, low educational attainment, and high university student population. Nottingham has a high concentration of its population living within the most deprived 10% areas.

[1] Lower-Layer Super Output Areas (LSOAs) are a standard statistical geography designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 LSOAs in England (Ministry of Housing, Communities & Local Government 2019)

[2] The Index of Multiple Deprivation provide a set of relative measures of deprivation for all areas across England, based on seven different domains, or facets, of deprivation: Income, Employment, Education, Skills and Training, Health and Disability, Crime, Barriers to Housing and Services, and Living Environment Deprivation (Ministry of Housing, Communities & Local Government 2019)

[3] Lower-Layer Super Output Areas (LSOAs) are a standard statistical geography designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 LSOAs in England (Ministry of Housing, Communities & Local Government 2019)

Figure 7: CME Cases by IMD National Decile



Comparing their Average Score, Nottingham was ranked the fourth most deprived of the 9 'Core Cities' behind Liverpool, Manchester and Birmingham in England. Figure 7 shows the percentage of CME cases falling into the areas of the top national decile of the national Index of Multiple Deprivation[4] (IMD) that are within the city boundary i.e. areas that are amongst the 10% of most deprived areas in the country.

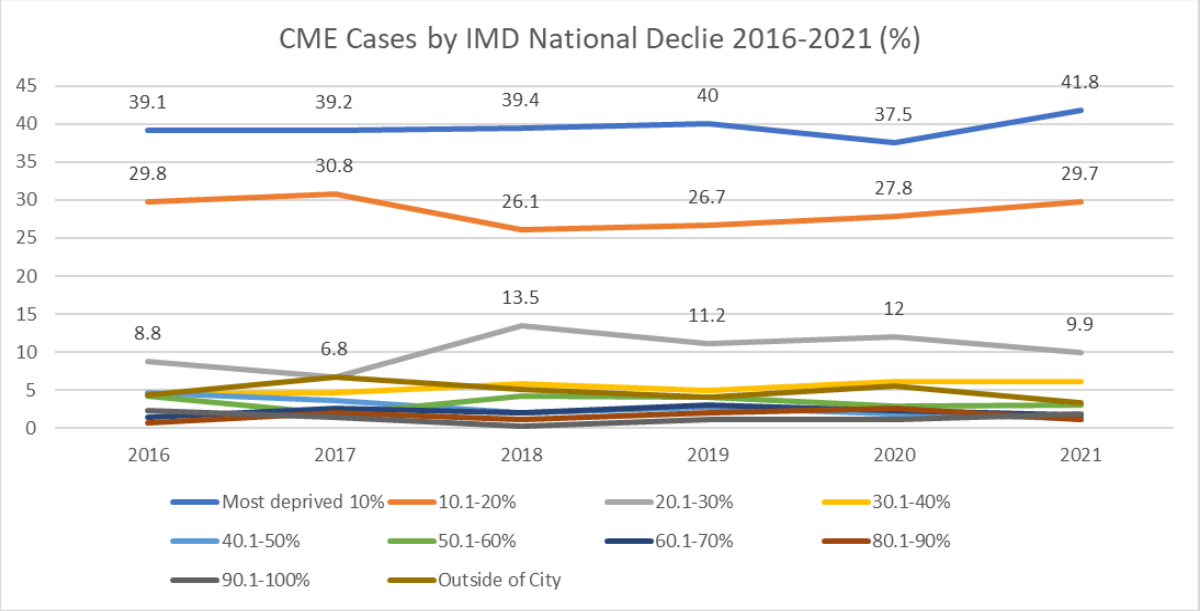
Map 1 on page 8 shows the locations of the CME cases with red dots in the areas falling within the 10% most deprived areas, orange dots in the 10.1% - 20% most deprived areas, yellow dots in the 20.1% - 30% most deprived areas, green dots in the 30.1% - 40%, turquoise dots in the 40.1% - 50%, blue dots in the 50.1-60%, purple dots in 60.1% - 70%, dark pink dots in 80.1%-90% and lilac dots in the 90.1%-100% least deprived areas of the city. 40% of the CME cases (red dots) were from nationally the 10% most deprived areas, followed by nearly 30% of the CME cases (orange dots) from the 10.1%-20% most deprived areas and 10.4% of the CME cases (yellow dots) from the 20.1%-30% most deprived areas.

A high percentage of the CME cases living in the most deprived areas may not be a surprising finding to local educationalists or to local political representatives in the city. However, it reinforces the fact that children living in the most derived households are the ones who most need to be in education are also the most likely to have children missing from education.

An analysis of the trends of the CME cases by national decile of IMD areas over time is shown in Figure 8. This demonstrates that to a great extent, there has been a consistent pattern established for the percentages of the CME cases within those areas from 2016 to 2021, with only very few minor fluctuations in some years.

[4] The Index of Multiple Deprivation provide a set of relative measures of deprivation for all areas across England, based on seven different domains, or facets, of deprivation: Income, Employment, Education, Skills and Training, Health and Disability, Crime, Barriers to Housing and Services, and Living Environment Deprivation (Ministry of Housing, Communities & Local Government 2019)

Figure 8: CME Cases by IMD National Decile (2016-2021)



The results demonstrate that the majority of the CME cases are associated with households living within the most nationally deprived 10% and the 10.1% - 20% areas within the City Council boundary and this has remained unchanged over the last five years.

While the CME teams experience is that there are some cases or families where an historical culture of transience and low school attendance is regarded as 'normal' the majority seek stability; they want to settle, build roots and have their children attending a local school. They generally move because they are forced to, for example due to circumstances such as eviction, family break up or unresolved problems within the neighbourhood.

It should however be noted (as it is clearly exacerbating the issue), that the Local Government Financial Settlement for Local Government which provides financial support from central government to local service provision has ceased having a 'multiple deprivation' element to it since 2013.

Changes to the HM Treasury model for distributing the Local Government Financial support from central government effectively 'locked in' the structure and pattern of distribution of central government revenue support to local authorities, based on the pattern of distribution at 2013 (Amin-Smith 2019). This meant that the already suboptimal and regressive Council Tax would inevitably become more regressive and unfair over time, as it would not react to changing circumstances (Ogden & Phillips 2020).

By 2016 the UK government accepted that major parts of the calculation were inadequate and unfair, and the "Fair Funding Review" was established with CIPFA and the LGA committed to seek a new mechanism based upon an up-to-date assessment of authority's relative needs and resources (Sanders 2021). By 2018 the government agreed that the three core components or 'cost drivers' of any new model should 'population', 'deprivation' and 'sparsity', together with additional cost drivers related to specific individual local authority services (Sanders 2018). Six years after acknowledging the need to

fundamentally change the model for distributing central government support to local areas there has been no change.

This section examines the rate of CME cases by population in City Council ward areas. To compare CME cases within the population for different sizes of age groups, we have used the number of CME cases per 1000 population. The population data by ward and for single years was only available for 2017 and for 2020. Therefore, the calculation was only applied to these two years to look at the rate of CME cases in each ward of NCC. For the CME cases, the age groups were defined by the national curriculum year for this project.

Table 1: The Rate of CME Cases Per 1000 Population by Wards in NCC

	2017				2020			
Ward	Aged 0 - 4	Aged 5-9	Aged 10-14	Aged 15-19	Aged 0 - 4	Aged 5-9	Aged 10-14	Aged 15-19
Aspley	0	13.50	24.97	3.88	0.59	12.88	15.06	4.08
Basford	0	6.30	21.92	5.55	0.00	16.08	17.77	2.75
Berridge	0	18.21	73.10	20.57	0.00	36.19	45.24	8.90
Bestwood	0	6.21	19.80	3.86	1.49	6.14	16.12	4.79
Bilborough	0	14.03	24.29	4.34	0.00	8.03	10.51	6.73
Bulwell	0	10.52	20.81	2.02	0.80	10.86	18.85	3.99
Bulwell Forest	0	1.20	13.18	5.83	1.23	6.13	7.29	1.47
Castle	0	44.44	80.88	2.97	0.00	76.92	71.43	3.52
Clifton East	0	4.24	11.64	2.91	0.00	14.05	9.45	5.63
Clifton West	0	5.54	8.53	0.00	0.00	3.35	6.04	2.69
Dales	0	18.67	47.86	14.07	0.80	20.94	43.67	16.22
Hyson Green & Arboretum	0	34.43	89.45	7.84	0.00	34.88	62.39	7.38
Leen Valley	0	11.44	30.45	22.49	0.00	18.55	31.16	14.68
Lenton & Wollaton East	0	20.58	51.06	0.74	0.00	18.27	26.75	0.22
Mapperley	0	16.91	18.83	8.99	1.07	19.78	14.14	3.62
Meadows	0	12.05	27.50	14.33	0.00	26.52	29.80	10.35
Radford	0	15.69	49.87	1.46	0.00	35.92	34.84	1.95
Sherwood	0	2.17	11.55	2.36	0.00	14.05	15.77	2.15
St. Ann's	0	12.04	39.28	2.91	0.00	28.31	39.02	4.49
Wollaton West	0	14.97	27.03	18.92	2.22	26.79	22.09	3.41
City total	0	13.03	32.30	5.80	0.46	18.75	24.56	4.52

Table 1 shows the rate of CME cases of different age groups in each ward. There was no CME case for 0-4 years group in 2017 and only a few CME cases (a small rate) in 2020.

For the **5-9-year age groups**, in 2017 the CME city average rate was 13.03 per 1000 children in those ages and the top three wards with the highest rates were in three wards, namely Castle, Hyson Green & Arboretum, and Lenton & Wollaton East. In 2020, the CME city average rate for this year group was 18.75 per 1000 children: a higher rate than in 2017. The top three wards with the highest rates were Castle (a substantially higher rate of 76.92 per 1000 compared to 44.44 per 1000 in 2017), Berridge and Radford, closely followed by Hyson Green & Arboretum.

For **10–14-year age groups**, the CME city average rate in 2017 was 32.30 per 1000 children population. The top three wards with the highest rates were Hyson Green & Arboretum, Castle and Berridge. In 2020, the CME city average rate was 24.56 per 1000 children, lower than that in 2017. The top three wards with the highest rates were Castle, Hyson Green &

Arboretum and Berridge, all with a lower rate as compared to that in 2017. The results indicate that the 10-14 years group had a higher CME rate per 1000 compared to the younger age groups and this may reflect the results shown in the section of the National Curriculum Year as this relates to the transition period from primary to secondary school in the city at this age.

The compulsory school leaving age in UK is 16 (NCY 11) so included in the 15-19 years group, are older teenagers (17-19 years old and some who are not yet 16) who will not necessarily be the responsibility of the local authorities and the children missing from education team. The statutory school age is from the first school term after a child is five until the 3rd Friday in June in year 11. After this time (whatever the precise age) they are outside of compulsory schooling and the scope of this project, and they are not therefore included in the CME database for this project.

It is clear therefore that the rates and inferences for this age group (15-19) will not be as robust as those for other age groups, for the reason that the City Ward 15-19 population included the 17-19 years olds but not the CME dataset for this project.

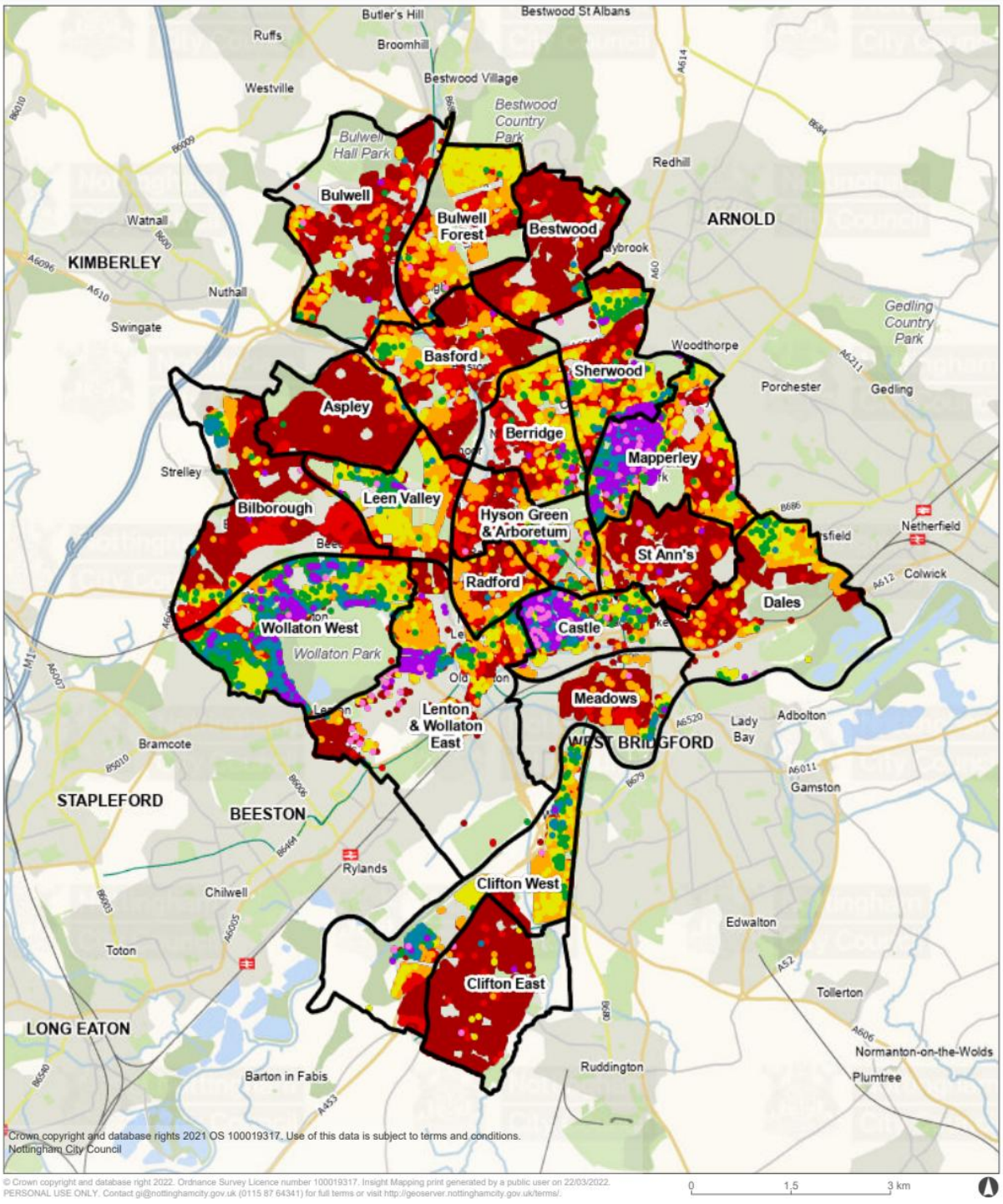
The CME city average rate in 2017 was 5.8 per 1000 children, much lower as compared to the other age groups. The top three wards with the highest rates were Leen Valley, Berridge and Wollaton West. In 2020, the CME city average rate was 4.52 per 1000 children and the top three wards with the highest rates were Dale, Leen Valley and Meadows. The wards with high rates in this age group were therefore different from those for the younger age groups.

In general, Berridge, Castle and Hyson Green & Arboretum were the three wards with high CME rates. When referring to Map 1 (on page 5) and Map 2 (on page 10), Berridge and Hyson Green & Arboretum were the two wards within the NG7 postcode area with a high concentration of CME cases and letting properties (Estates). This again provides more evidence to support engagement with local ward councillors aimed at further reducing CME cases in these ward areas.

Although Castle ward also had high CME rates for the age groups of 5- to 9-year-olds and 10 to 14 year-olds, it is also the ward with the least number of 5 to 9 year-olds population (135 in 2017 and 130 in 2020) and 10 to 14 year-olds (136 in 2017 and 168 in 2020) population in Nottingham City. The high rates are possibly due to the concentration of hotel accommodation in the area being used as a temporary address to accommodate families of refugees and asylum seekers short term.

Moreover, the ward areas of Lenton & Wollaton East and Wollaton West also appeared to have some high CME rates in different age groups. This may be influenced by the two universities, one with a medical school, which are close to these two wards and that the academic and medical professionals with relatively high incomes are likely to move in and out of these areas. Map 3 shows the Residential Properties by Council Tax Band and shows residential properties with the high council tax band (E, F, and G) are concentrated in the areas of Lenton & Wollaton East and Wollaton West. The advantages of proximity and better housing, suggests these areas are likely to be appealing to these professionals.

Map 3: NCC Residential Properties by Council Tax Band



3. Analysis of the characteristics of CME Cases in Nottingham City.

3.1 CME Cases by Gender

Figure 9: CME Cases by Gender 2016-2021

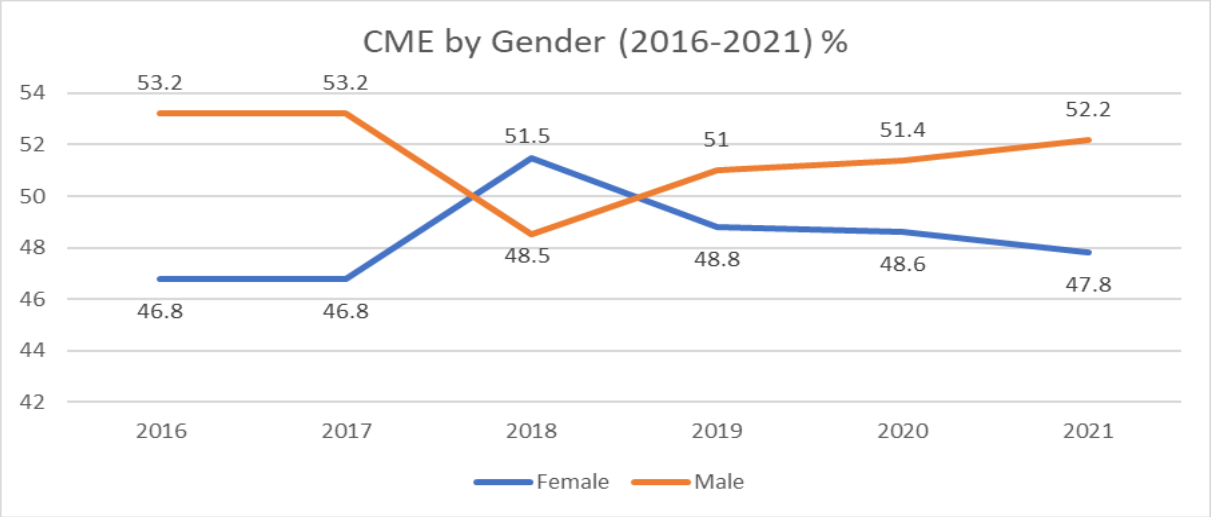


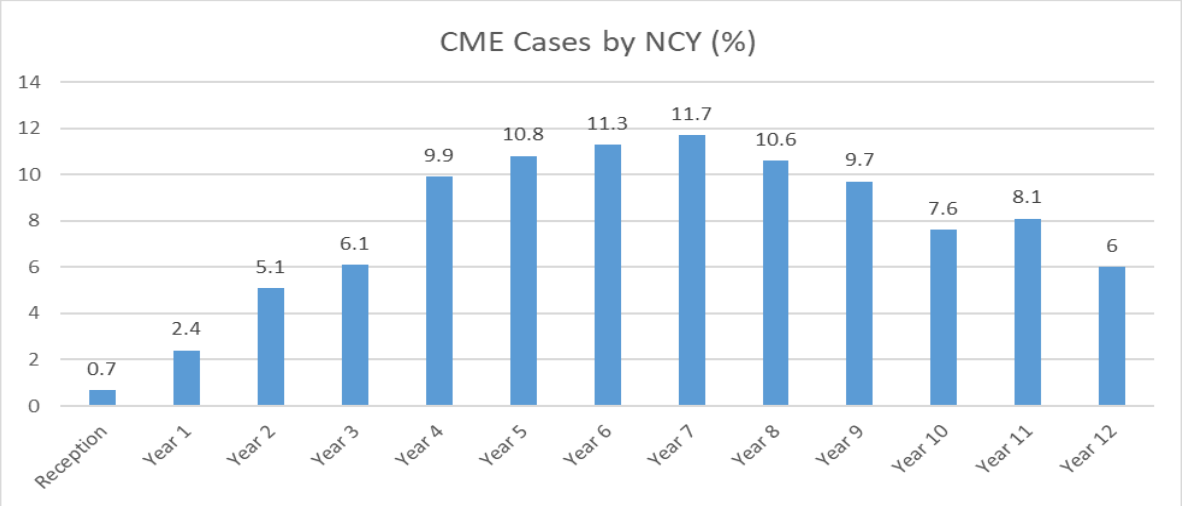
Figure 9 shows the trends of the percentage of cases by gender over time. Overall, there has been a fairly even distribution of male (51.5%) and female (48.5%) CME cases in the City. Generally, the patterns were stable and show that there were slightly more male CME cases, apart from in 2018 where there was an increase in female CME cases.

The results indicate that the pattern of children missing from education are not gender based but are more likely to be associated with family situation and family composition.

3.1. CME Cases by National Curriculum Year

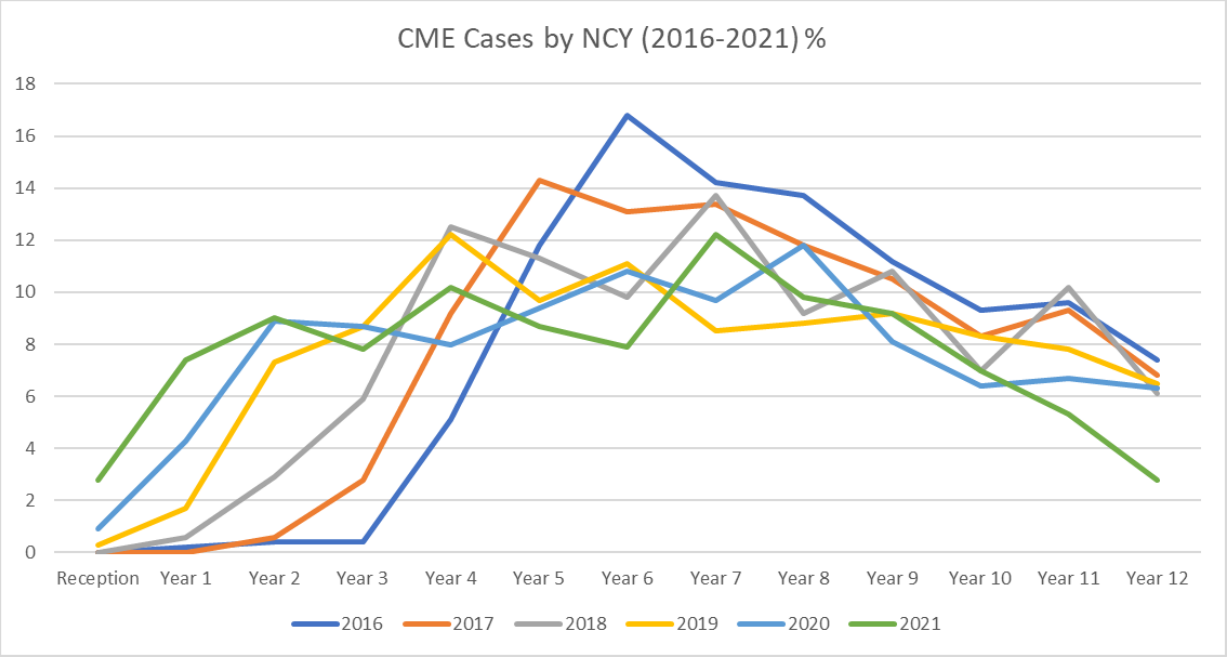
Examining CME cases by the distribution of the National Curriculum Year (NCY), Figure 10 demonstrates a 'bell shape' distribution, reaching its peak in Year 7 (11.7%) with relatively high percentages between Year 5 to Year 8.

Figure 10: CME Cases by National Curriculum Year (NCY)



Exploring the annual patterns of CME cases by National Curriculum Year over time from 2016 to 2021, Figure 11 reveals a similar picture to that shown in Figure 10, with the peak between Year 5 to Year 8. This demonstrates a relatively consistent pattern every year and suggests some influence from the national curriculum years where there are high volume of CME cases.

Figure 11: Trends of CME Cases by NCY Yearly



The CME team suggests that two possible factors may be part of the reason, one generic and one very specific. Firstly, and typically, children move from primary education in Year 6 to secondary education in Year 7. From Year 5 to Year 8, parents tended to consider that this may be the best time to relocate the family as the transition from primary to secondary will happen regardless of location and the relocation will have less impact on their children's education around those year groups as opposed to other years.

More specifically the CME team's experience with working with CME families appeared to suggest that more children from the Roma and Traveller communities were more likely missing education once they finished their primary education, and this could be part of the reasons for the high percentages of CME cases from Year 6 to Year 8.

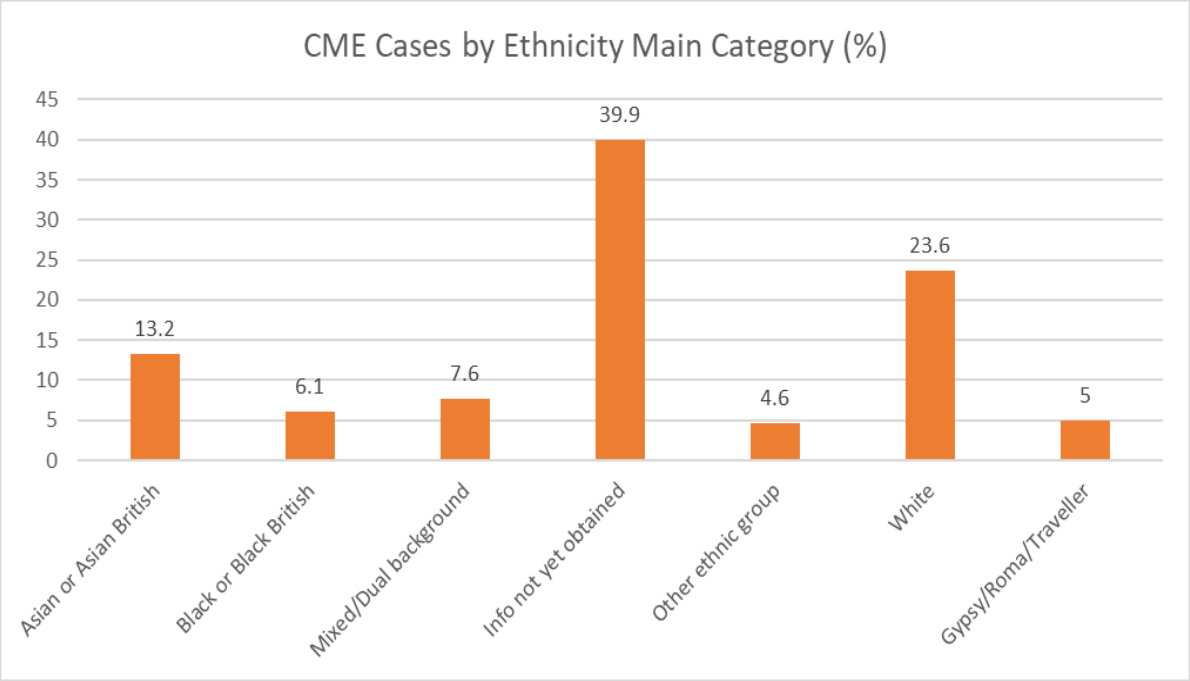
Moreover, Figure 11 demonstrates that from Year 5 onward, the patterns over time were to a large extent reasonably stable. However, the trend analysis shows that for the younger year groups (reception year to Year 4), there was an increase in percentage as the years went by. A more detailed figure showing the results of the examination of the CME cases by NCY individually from 2016 to 2021 is attached as Appendix 1 to this report.

The reason for the increase in the younger year groups was acknowledged by but is ultimately unknown to the team. It may have something to do with the new wave of immigration coming

into the city. Alternatively established families may be more financially secure or have more routines lifestyles, at this stage we don't know. It is an area where more investigation is needed and at the very least suggests a need for continuous monitoring on the development of the CME cases for these year groups.

3.2 CME Cases by ethnicity

Figure 12: CME Cases by Ethnicity Main Category (%)



It was not mandatory to reveal ethnicity as part of the CME monitoring process. When examining the distribution of the CME cases among different ethnicity groups using the ethnicity main category, Figure 12 reveals that 40% (the highest percentage) of the CME cases fell into the category of *Information not yet obtained*. The *White* ethnic background had the second highest percentage (23.6%) of CME cases, followed by 13.2% (the third highest) of the CME cases from the *Asian or Asian British* ethnic background. A more detailed breakdown of ethnicities produced through the use of the Department of Education's main codes can be found as Appendix 2 to this report.

The CME team suggested that giving out information relating to their ethnicity remained challenging for some ethnic minorities, particularly if they had previous unpleasant experience of revealing their ethnicities. Similarly, schools referring cases often failed to collect or include information regarding children's ethnicities, thus contributing to the high percentage of *Information not yet obtained*

When compared to the results of the School Census in 2021 the gap was substantial. In the city schools census, there was only 1.5% of pupils classified as *Information not yet obtained.* (Nottingham Insight 2021, Jan 2021 Pupil characteristics). This suggest more research and

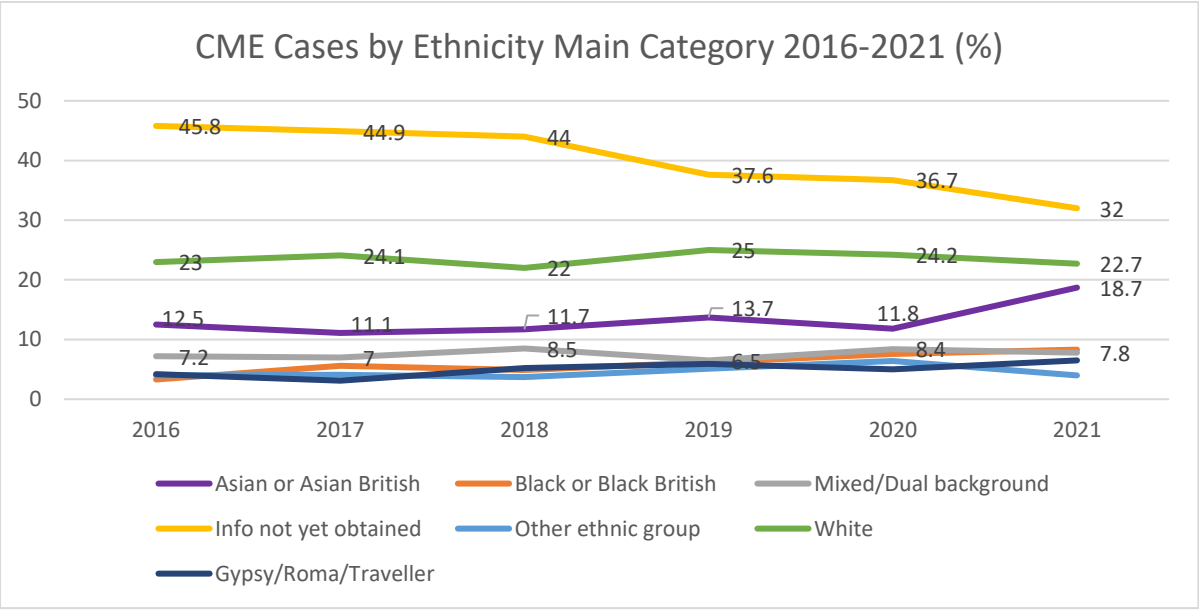
information is clearly needed to understand the reasons and barriers to obtaining children's ethnicities from the families of CMEs, but this is outside of the scope of this project.

The experience from the CME team suggests that cases from the *White* ethnic background predominantly could be resolved more quickly. In contrast, CME cases from ethnic minorities group appeared to be more difficult to track and trace, sometimes with the added complication of communication issues. Some cases *are due to the family returning to their former country of residence and there are countries where it can be very difficult to establish which school their children are attending in that country, particularly if the country discourages the use of e-mail communication or the schools have very limited access to technology.* Nevertheless, it is the duty of the CME team to identify all children who were missing from school and help them back to education regardless of where they were from or what their ethnicities are.

Figure 13 looks at the trends of the ethnicity groups over time. It demonstrates that although the percentages for the *Information not yet obtained* group remained high, there was a gradual decrease of over 10% (from 46% to 32%) between 2016 and 2021. This shows an improvement in the recording of ethnicity information for the CME cases. The trends for all ethnicity groups remained relatively stable from 2016 to 2021, apart from a sharp increase from 2020 to 2021 for the *Asian or Asian British* ethnic background group.

The local authority has been providing training workshops to schools in order to raise awareness and importance of the quality of data collection and recoding of ethnicity. Although the trend is encouraging, it also indicates the amount of work that still needs to be done to approach the standard established by the school census. To continuously improve the quality of information relating to ethnicity, NCC must engage and generate 'ownership' from schools and education establishments to consciously act to collect the information regarding children's ethnicities, whether it was in the initial meeting of admissions, or when children commenced their schooling at the school or establishment.

Figure 13: Trends of the CME Cases by Ethnicity Main Category from 2016 to 2021



3.3 CME Cases by referral base

This section examines the CME cases by the origin of the referral and particularly distinguishing the types of school when schools have made the referral.

Figure 14: CME Cases by Referral Base and School Type

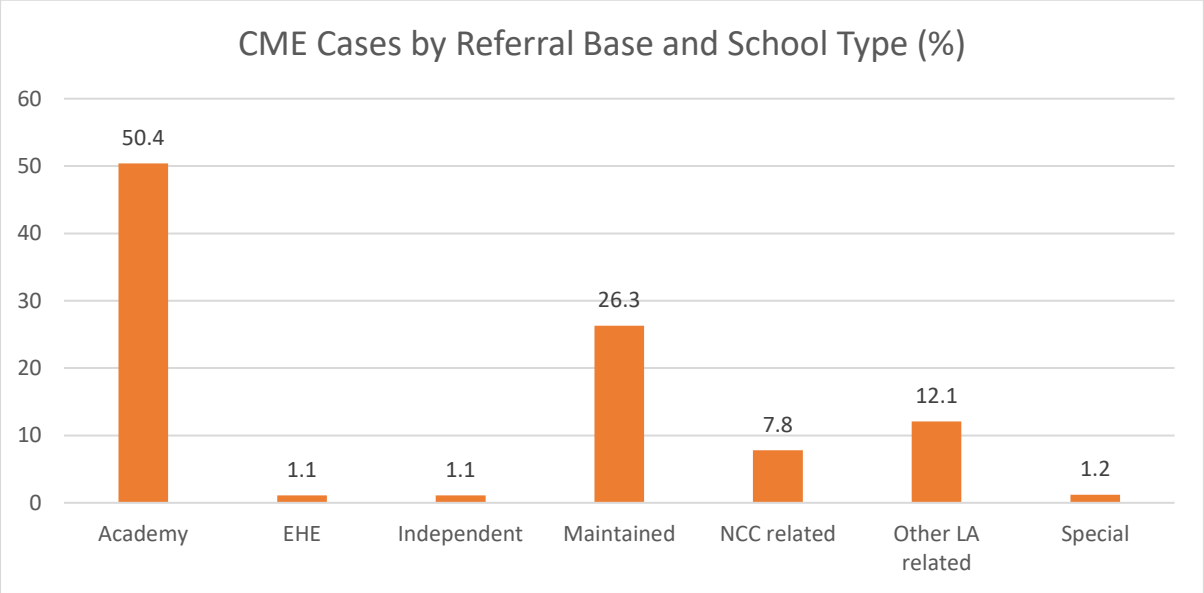
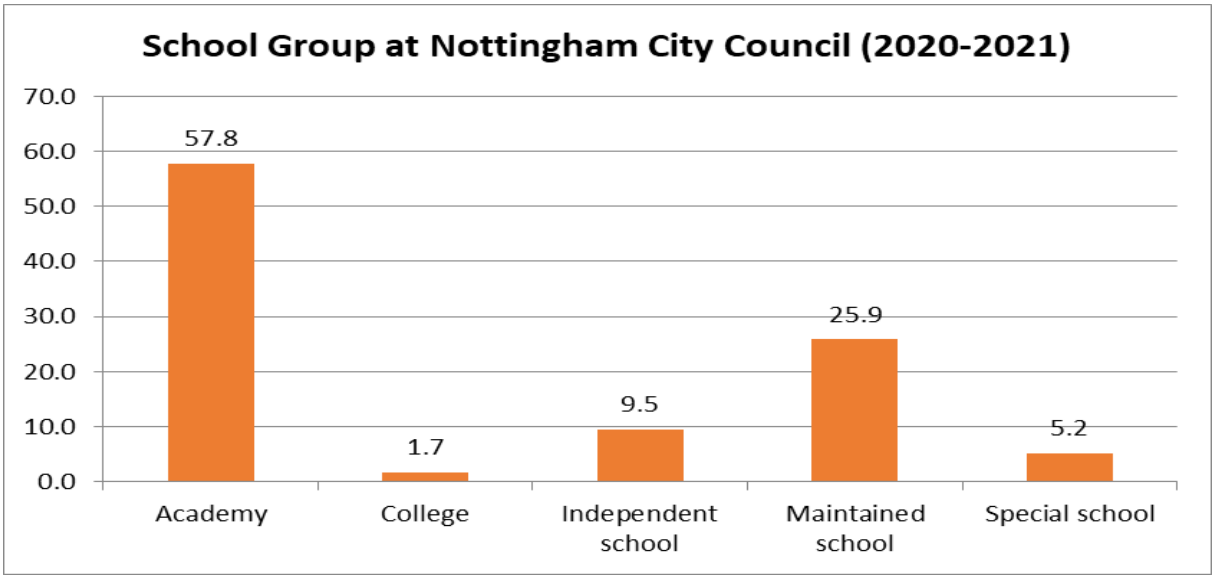


Figure 14 shows that there was a wide range of sources referring children who might have missed full-time education to the NCC CME team for investigation. Half (50.4%) of the CME cases were referred by the Academy schools, followed by 26.3% by NCC maintained schools (community schools), 12.1% by other local authorities related sources, such as CME teams, children's centres and health centres, along with 7.8% NCC related sources, for example NCC internal teams, private nursery and early years provisions, health provisions and customer hubs. Much smaller numbers came directly from independent or special school or those from Elected Home Education (EHE).

Figure 15: School Group at Nottingham City Council Boundary 2020-2021



According to the Department of Education School Information 2020-2021, Figure 15 shows that in Nottingham City Council, out of total 116 schools, nearly 60% of the schools were Academy type of schools, followed by 26% of the NCC maintained school (community schools). Therefore, it could be anticipated that more than half of the CME referral would have come from Academy schools and the same situation could apply to the NCC maintained school type (community school type).

Figure 16 shows the referrals from Academy schools in detail. It shows that among the different Academy trusts (2804 in total), the highest percentage (19.3%) of the referral were from LEAD Academy Trust (Lead, Empower, Achieve, Drive), followed by 15% from Greenwood Academy Trust (GAT), 14.2% from Transform Trust and 13.2% from Djanogly Learning Trust.

The results from Figure 14 and 16 also demonstrate that the NCC CME team has established good working relationships not only with schools (Academy schools, NCC community schools, Independent schools and Special schools) but also with internal council teams (school admission, Special Education Needs team, Children & Family Directory, Social Care), wider NCC partners and agencies (Health provisions, private nursery and early years provisions, school nurse, Customer Hubs, Children Centre Multi Agency Team), as well as with external partners (the CME teams, schools and services from other local authorities).

Figure 16: CME Cases by Referral Base - Academy Trust Type

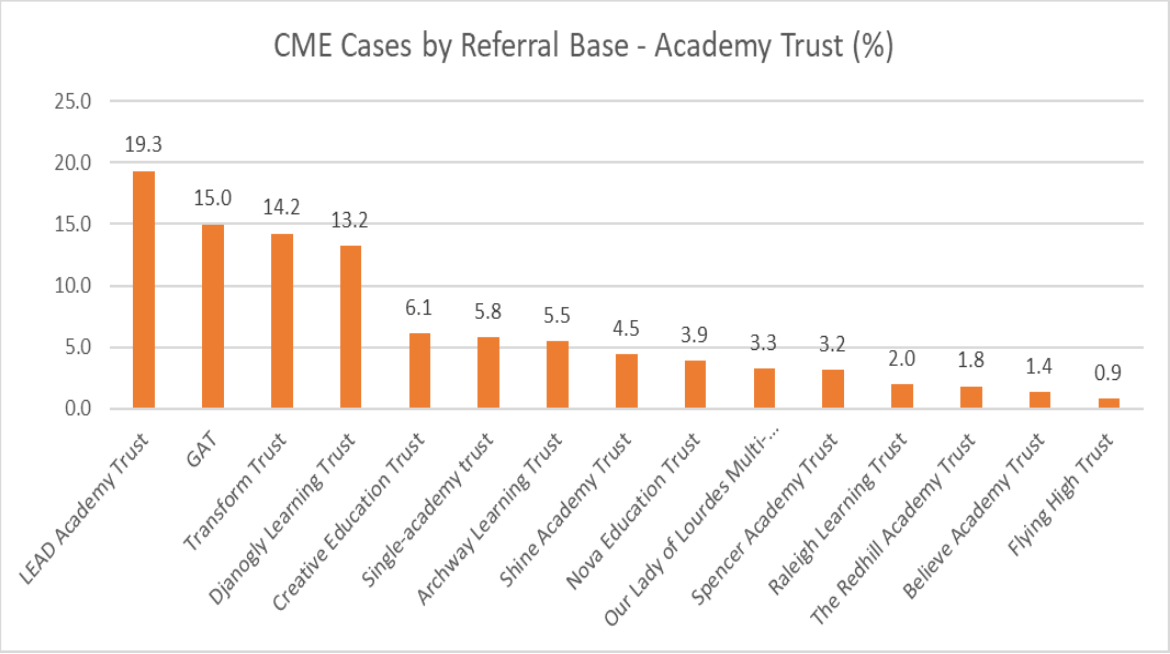


Figure 17: CME Cases by Referral and School Type (2016-2021)

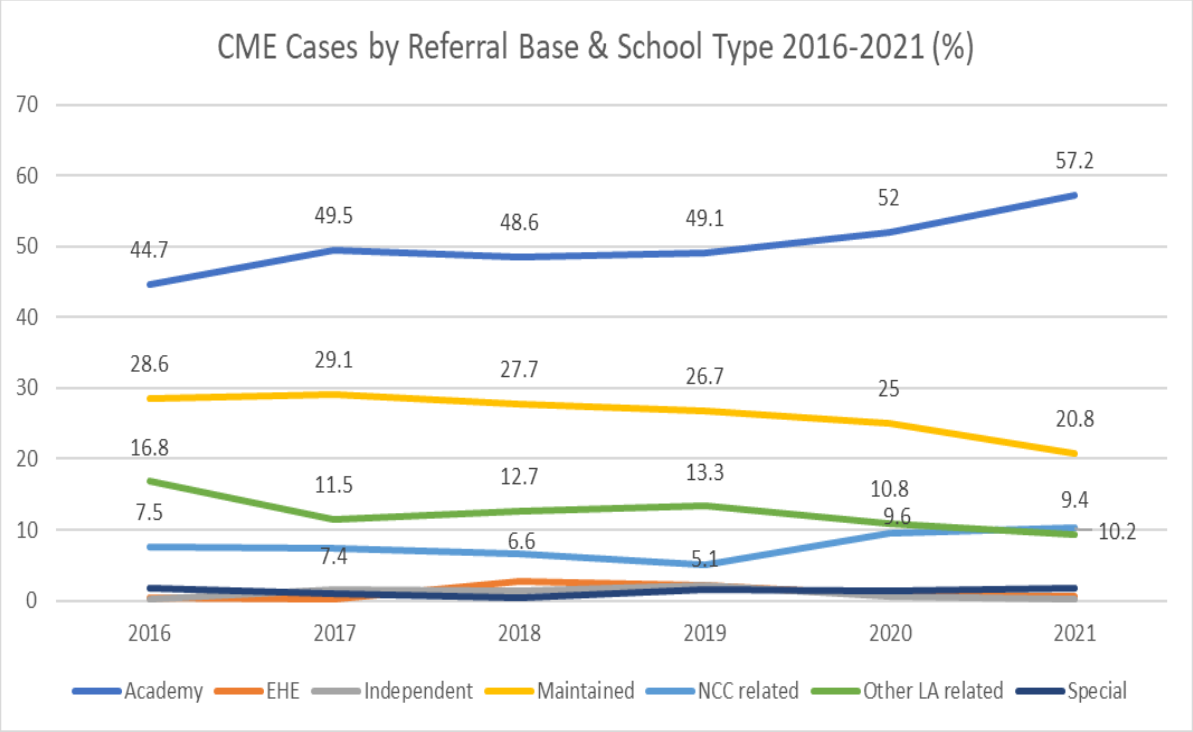
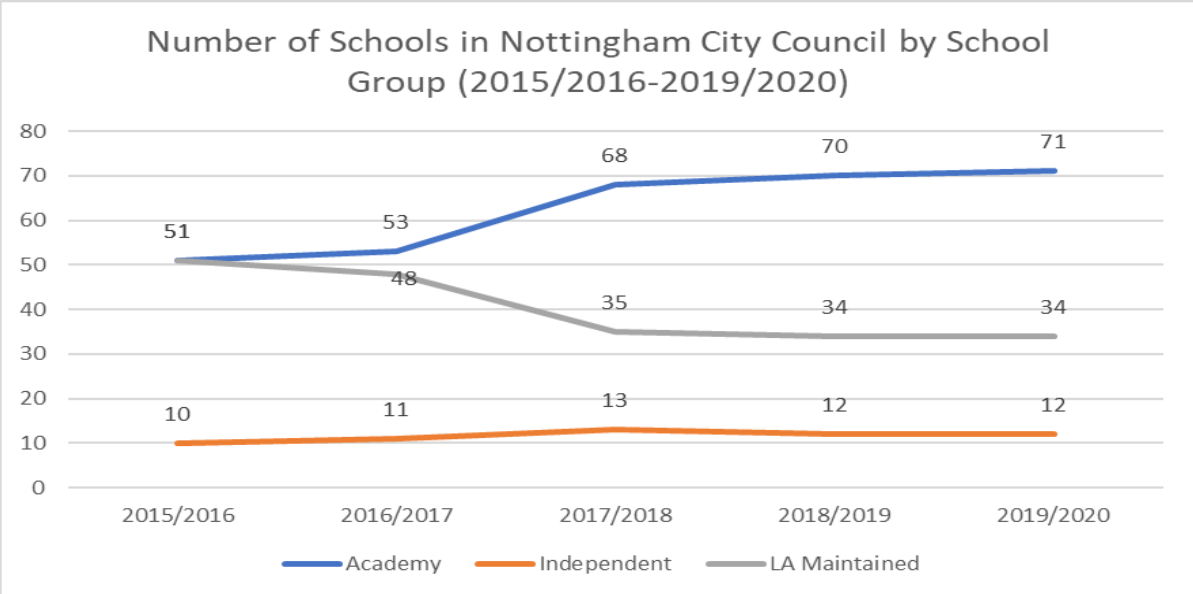


Figure 17 presents the trends by examining the CME cases by referral base from 2016 to 2021. The results show that the percentages of the referrals from the Academy schools increased steadily from 2016 to 2021. In contrast, the percentages of the referrals from community schools declined gradually from 2016 to 2021. The percentages of the referrals from other LA related sources gradually decreased from 16.8% to 9.4% over time. The percentages of referrals from NCC related sources were also gradually declined (7.5% to 5.1%) from 2016 to 2019 but climbed up to 9.6% in 2020 and 10.2% in 2021.

Figure 18: Number of Schools in Nottingham City Council Local Authority from 2015/2016 to 2019/2020 by school group.



One part of the explanation for an increase in referrals from the Academy schools and a decrease in referrals from the NCC maintained schools over time is provided by Figure 18. According to the data from GOV.UK, in the NCC administrative area, the number of Academy schools gradually increased from 51 in 2015/2016 to 71 in 2019/2020 while the number of NCC maintained schools reduced from 51 in 2015/2016 to 34 in 2019/2020. There was a notably sharp decline between 2016/2017 and 2017/2018. Therefore, it would have been anticipated that the number of referrals coming from the Academy schools would be growing over time.

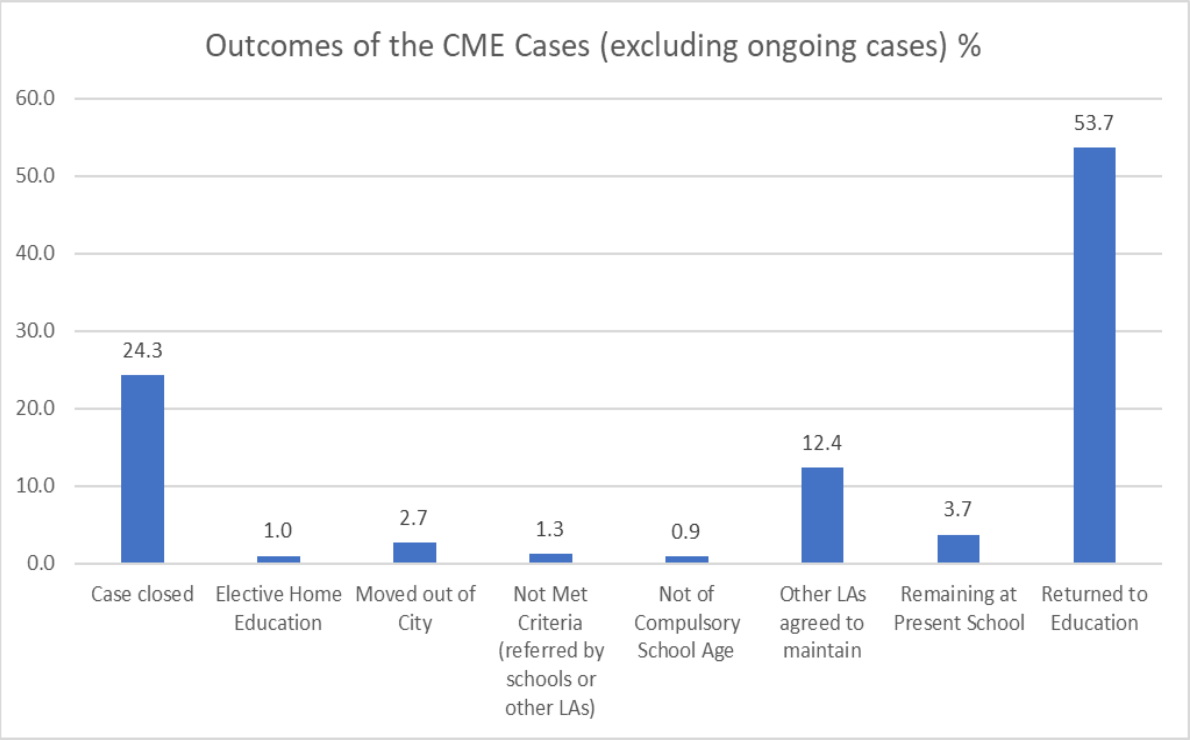
4. CME case outcomes

4.1 Case Status and Outcomes

In the study period 5615 cases were considered, 71% of the cases resolved by the CME team, with 29% open ongoing cases.

Figure 19 *inter alia* shows the outcomes of the cases that were resolved with the majority of the cases were *returned to education* (53.7%). The outcomes of *returned to education*, *remaining at present school* or *other local authorities agreed to maintain,* all indicated children formerly missing from education were back to schooling (in total 70%) which is the ultimate objective of the CME team.

Figure 19: Outcomes of the CME Cases resolved



The outcome of *case closed* (24.3%) have in the past included a range of outcomes including, *no further action needed*, *child accommodated*, *task completed*, *monitoring* to ensure needs being met. The *'no further action needed'* category could have related to an application for a school place being with admissions or the child returning to school shortly after the case has been referred. Case closed is therefore most often the result of an application being submitted to the school admissions service, who then take charge of the case.

The other terms are now in practice considered too general by the CME team and are no longer adequate or fit for purpose. The CME team acknowledge that this may be an appropriate time to review the categories and clarify new definitions which can then be embedded in the CME process.

Figure 20: Trends of outcomes of the resolved CME Cases 2016-2021

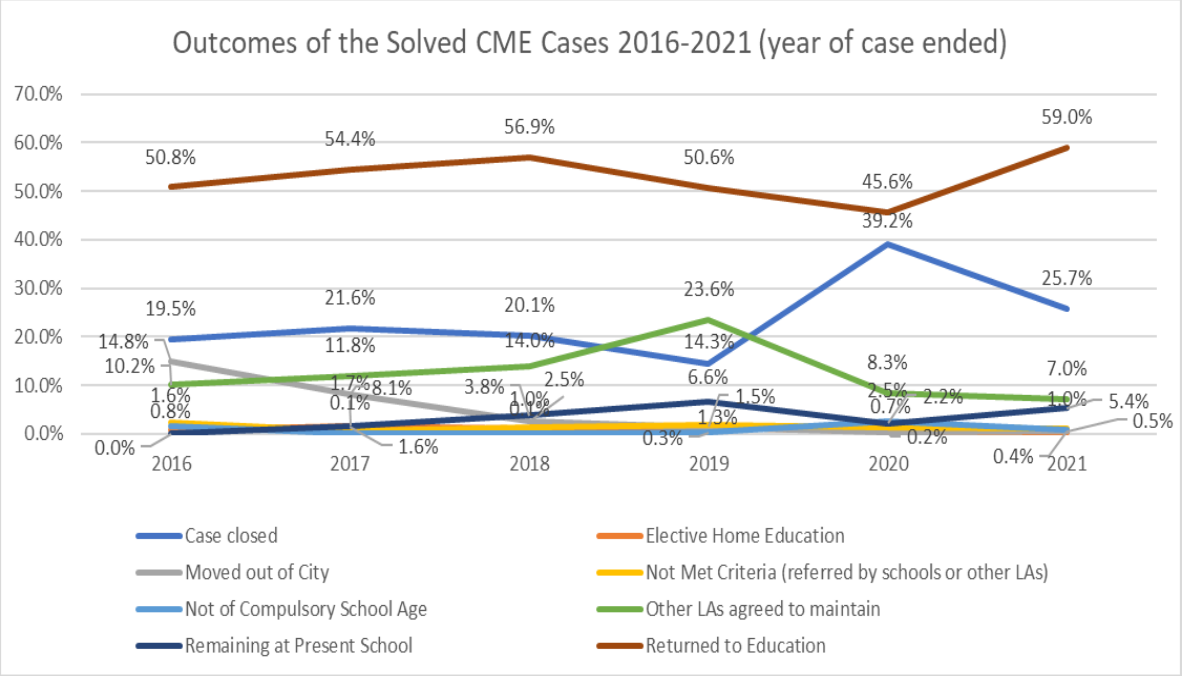
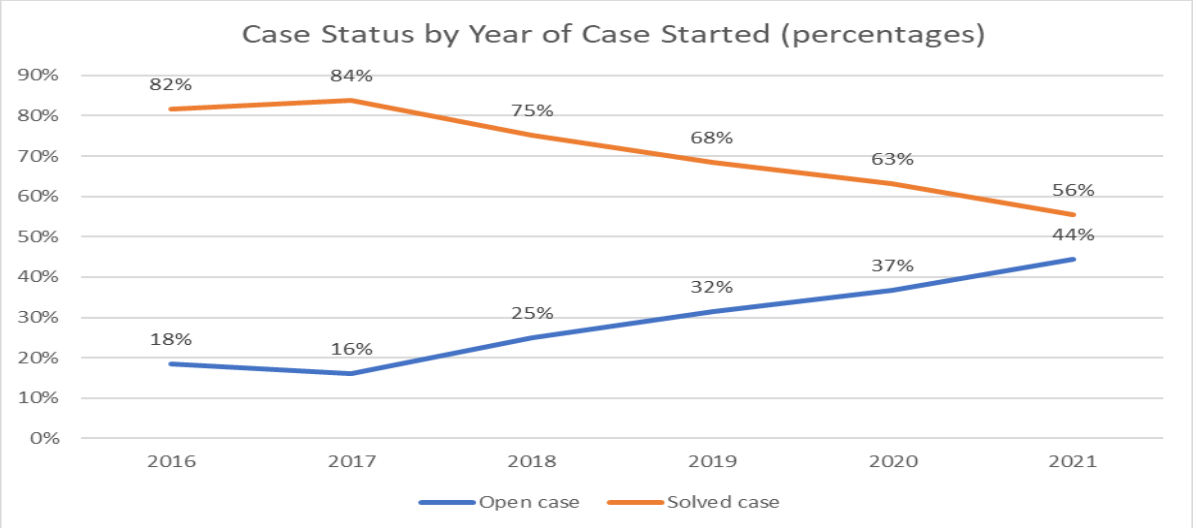


Figure 20 shows the trends in terms of outcomes in resolved CME cases from 2016 to 2021. From 2016 to 2018 there was a steady increase in the percentage of cases with the outcome *returned to education* and then a dip in 2020 and an upturn in 2021 to 59%. The trend for *case closed* remained steady from 2016 to 2018 but declined in 2019 and then sharply increased to 39.2% in 2020 and back down to 25.7% in 2021. The trend for *other LAs agreed to maintain* was stable until an increase in 2019 and then a declined to 8% in 2020 and 7% in 2021. The trends for other outcomes remained very steady over time.

4.2 Length of time to resolve cases

As mentioned above of 5615 total cases, 71% of the CME cases were resolved and 29% of the cases were under ongoing investigation (as at the date of data collected).

Figure 21: CME Case Status



Looking at the trends in the status of cases (resolved and open cases) from 2016 to 2021, Figure 21 shows that the *percentages* for resolved case gradually decreased and the percentages for open case gradually increased over time. This is because the 'time' starts immediately when a case is opened and increases as one goes back to include previously unresolved cases. In 2021, more than half of cases were resolved and this included 44% that were the accumulations of previous unsolved cases.

The results indicate continuous working to resolve the CME cases as the previous unsolved cases were rolled forward into the next year regardless how long it would take for the team to resolve an individual case. There is no annual deadline for CME team as the work will not finish until the case is resolved or when the children are not within the compulsory school age. Although the capacity of the CME team is limited, the LGA believe work to safeguard this vulnerable group of children and families is "crucial and should not be deprioritized" (Local Government Association 2020).

Table 2: Days of Solving Cases: 7 Days

Days	Frequency	Cumulative Percent
0	343	8.6
1	171	12.9
2	67	14.6
3	53	15.9
4	72	17.8
5	57	19.2
6	58	20.6
7	64	22.3
30		40.5
60		52.9
90		59.3
180		70.1
270		77.2
365		81.8

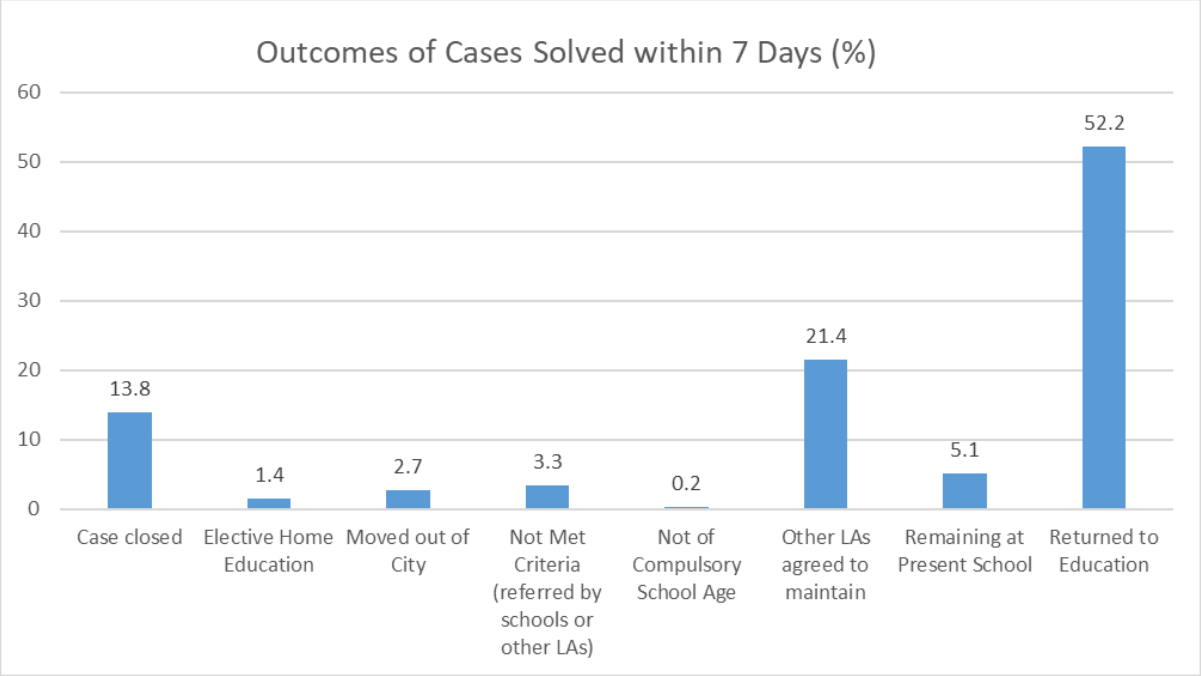
Analysis of the duration of time that it takes for the CME team to resolve a case, reveals that the range of cases being resolved was extremely varied. Some cases could be resolved on the same day as when the CME team started the investigation, while in contrast, it took 2307 days (more than 6 years) to solve one extreme case.

Table 2 shows that 22.3%, nearly a quarter of the cases, were resolved within 7 days when the CME team started the investigation. 40.5% of the cases were resolved within a month and more than half of the cases were resolved within two months. 81.8% of the cases were resolved within a year.

The table reveals the persistence of the work that the CME team needs to carry out the work. It takes time to solve complicated cases but once a piece of new information occurs that will enable the team to locate the families and help the children back to education, the team will respond and persevere, regardless of how long the case has been open. The team regularly reviews 'old' cases, and the work is not finished until the case is solved or when the children reach the non-statutory school age.

As almost a quarter of the cases were resolved by the CME team within 7 days, we investigated what kinds of outcomes were achieved by acting promptly. Figure 22 shows that the majority (52.2%) of the CME cases returned to education and 21.4% of the cases were resolved by communication with other local authorities, followed by 13.8% of cases closed by meeting children's needs, carrying out family assessment or changing the caseworker.

Figure 22: Outcomes of Cases Solved within 7 Days



It is worth noting that communication with neighbouring local authorities to ensure that children are back in education indicates the importance of partnership working, sharing information, and collaborating with other local authorities to resolve CME cases. The NCC CME team belongs to the Midlands Regional Group which holds regional meetings four times a year to share and update recent policies, guidance, and good practices regarding children missing from education.

Good partnership working has also established between the CME team and various internal teams and agencies, such as Health, Social Care, Housing and Benefits, Women's Aid, and Youth Justice within the NCC. This is reflected in cases being referred by a wide range of partners and agencies, such as schools, other local authorities and internal services and agencies within NCC (see section 3.3 above). Such proactive partnership working among local authorities was highlighted by the LGA (2020) and by this study as a key activity to prevent vulnerable children missing their entitlement for full-time education.

4.3 Outcomes and days to resolve cases for the CME cases in the 10% most deprived areas

As 40% of the CME cases were from the 10% (nationally) most deprived areas in this project, it is worth examining the outcomes and duration of resolving cases for this particular cluster.

Figure 23 shows very similar percentages for the outcomes of the investigations were established for the CME cases (2221) within the 10% most deprive areas when compared to that for all 5615 cases.

Among the 2221 CME cases, 26.5% of them were open on-going cases as compared to 29% of that for all cases together. Among the resolved cases, the majority of the cases (52.4%

compared to 53.7% for all cases) *returned to education*. 25.2% (compared to 24.3% for all cases) of the cases were closed mostly by closing in general (no specific reasons mentioned), changing the caseworker and needs being met. 12.2% (12.4% for all cases) of the cases were solved by *other LAs agreed to maintain*.

Figure 23: Outcomes of the resolved cases within nationally the 10% most deprived areas

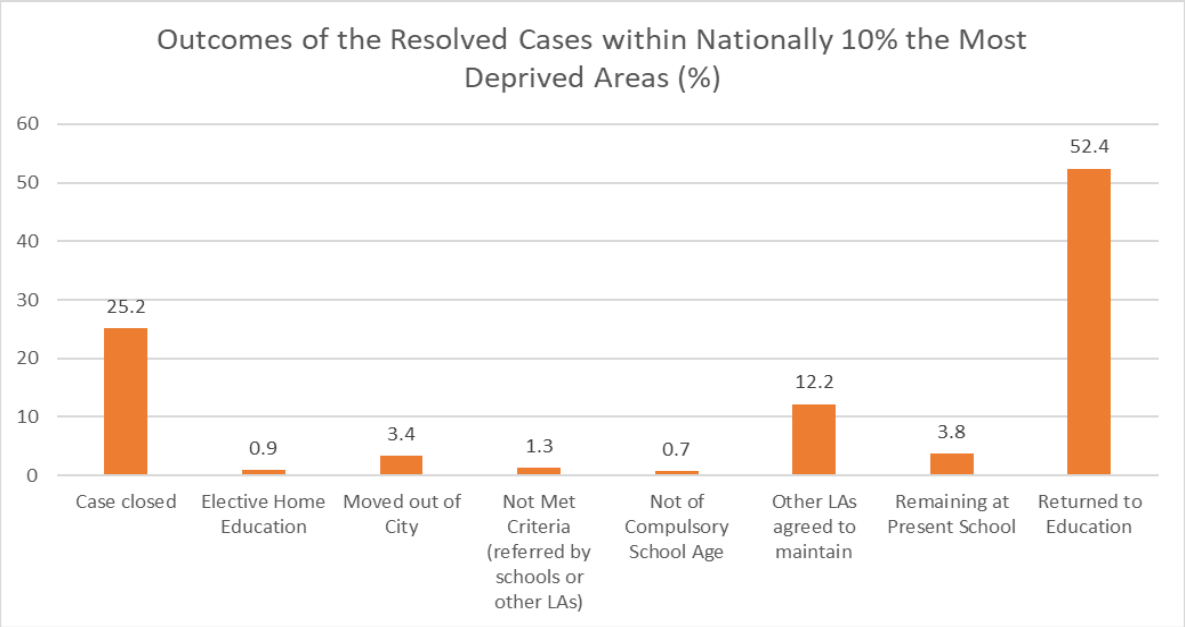


Table 3: Days of solving the cases for the CME cases within nationally 10% the most deprived areas

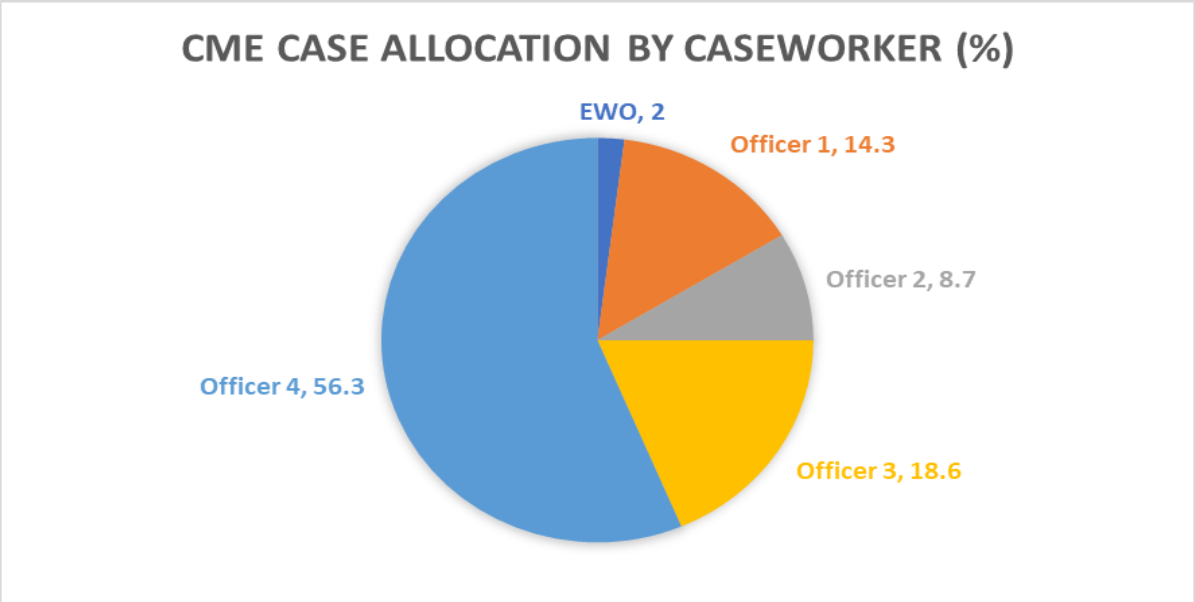
Days	Frequency	Cumulative Percent
0	134	8.2
1	75	12.8
2	27	14.5
3	15	15.4
4	20	16.6
5	25	18.1
6	17	19.2
7	29	21
30		39.1
60		52
90		58.6
182		70.7
270		78
364		82.9

Exploring the duration taken to resolve the cases within nationally the 10% most deprived areas in NCC, produces an almost identical table (Table 3) for this cluster when compared to all cases (Table 2 on page 32).

21% of the cases were resolved within 7 days when the CME team started the investigation (22.3% for all solved cases). 39% of the cases were resolved within a month (40.5% for all solved cases) and more than half (52%) of the cases were resolved within two months (52.9% for all solved cases). 82.9% of the cases were resolved within a year (81.8% for all solved cases).

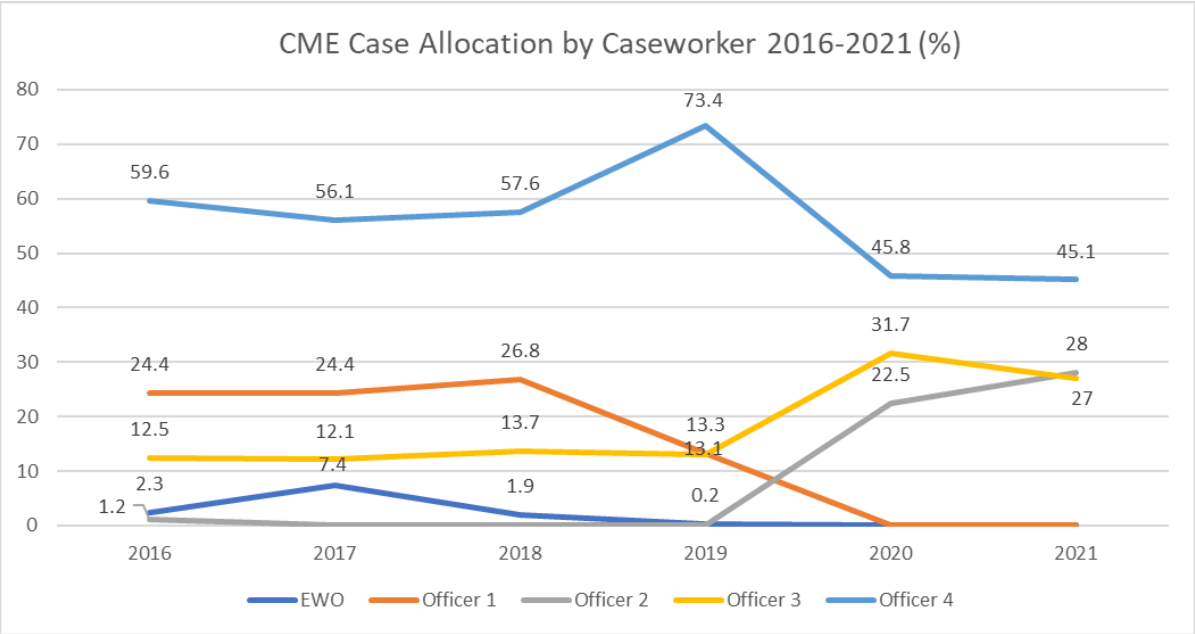
5. Workforce and workload

Figure 24: CME Case Allocation by Caseworker



The CME team currently comprises two full-time staff (one with managerial responsibility) and one part-time member of staff at the present. Figure 24 demonstrates that since 2016 there have been four CEM officers at some stage of the working on the cases, with some Education Welfare Officers' support (2%). It also shows that one officer (a full-time member of staff) was responsible for more than half (56.3%) of the case allocation.

Figure 25: Trends of CME Case Allocation by Caseworker 2016-2021



Upon a closer examination, Figure 25 shows that Officer 4's case allocation remained high from 2016 to 2018 but was reduced to less than 50% in 2020 and 2021 after a sharp increase to 73.4% in 2019, with Officer 2 and Officer 3 (two new members of the team at that time) picking up the case load from 2020. The support from the Education Welfare Office and the work by Office 1 ceased from 2020.

Figure 26: Percentage of CME Case Solved by Caseworker

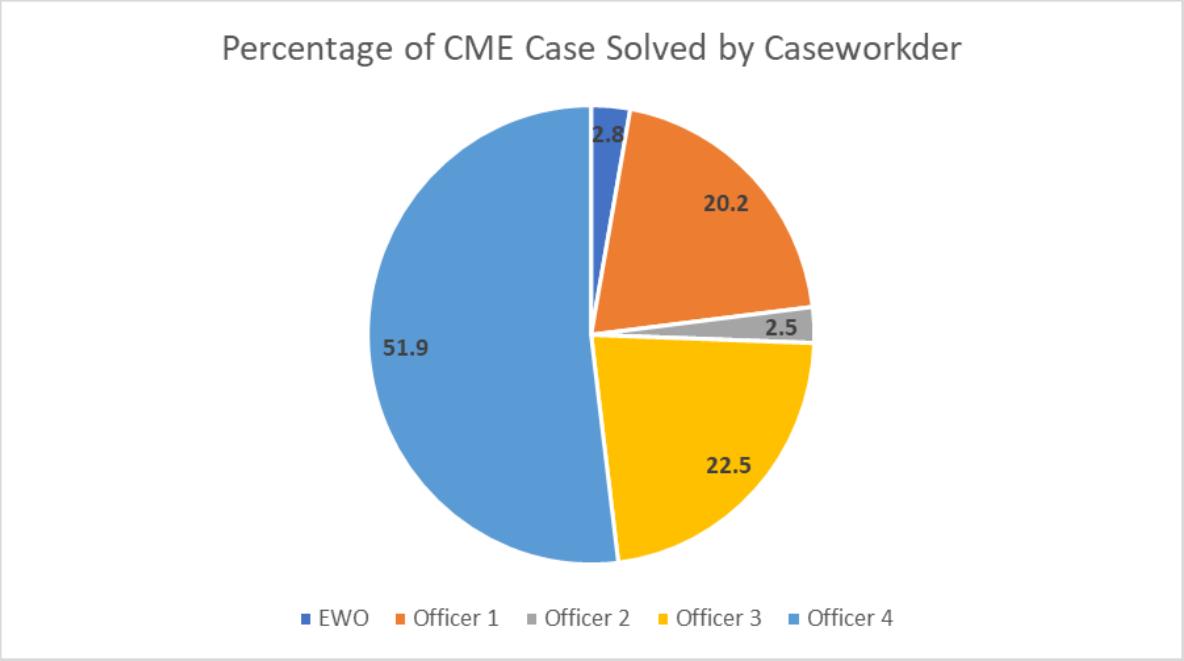


Figure 26 shows the percentages of the cases solved by the CME officers. Officer 4 solved more than half of the cases, followed by 22.5% by Officer 3 (a part-time officer) and 20.2% by Officer 1 (who left in 2020).

There were approximately 1000 CME cases on average each year. The size and constitution of the workforce and the number of cases have clear implications for the amount of time officers are able to spend on each case. The more cases the officer has, the less depth he or she will be able to go into each case. Better databases and improved technology have helped the investigations. Examples of databases include the Department for Educations' Get Information About a Pupil, a government agency and Benefits database, Liquid Logic Database, Capita One databases (both education and admissions), and the National Health Spine. Improved speed and accuracy of search engines has also helped.

Nevertheless, an average of 1,000 cases per year, is a heavy caseload for 2 and half full-time equivalent CME officers (one full-time, one full-time with managerial responsibility and one part-time) to investigate yearly. The LGA report (2020) suggests that the numbers are likely to rise.

6. Regression Analysis – Unsolved Cases and Case Length

Additionally, we undertook two simple regression analysis, (specifically using the binary logistic model), to further enhance the understanding of the relationships between whether cases were solved or unsolved; and how long it took if the case was solved using variables, such as gender, type of education, ethnicity, location and deprivation.

The purpose of applying this analysis is to measure the probabilities of the cases being unsolved (the dependent variable) based on some explanatory variables i.e., gender, type of education, ethnicity, location and deprivation (the independent variables) (Osborne 2008).

Table 4: Determinants of unsolved cases and case length

	Case unsolved		Days taken (if solved)	
	Coefficient	Standard error	Coefficient	Standard error
Female	0.020	(0.012)	-3.901	(11.265)
(Compared to male)				
Secondary school	-0.025**	(0.012)	26.708**	(11.312)
(Compared to primary)				
White	-0.113***	(0.017)	-84.924***	(14.902)
Asian	-0.075***	(0.019)	-77.125***	(18.073)
Mixed	-0.129***	(0.025)	-65.004***	(21.483)
Black	-0.048*	(0.027)	-86.110***	(24.102)
GRT	-0.036	(0.029)	-41.734	(28.031)
Other	0.092***	(0.029)	11.049	(30.916)
(Compared to no information)				
NG2	-0.035	(0.043)	-106.963**	(42.022)
NG3	-0.104**	(0.042)	-150.513***	(41.442)
NG5	-0.095**	(0.042)	-124.636***	(41.427)
NG6	-0.092**	(0.043)	-141.656***	(41.726)
NG7	0.078**	(0.040)	-66.872*	(39.740)
NG8	-0.080**	(0.040)	-97.249**	(39.679)
NG9	-0.267**	(0.106)	-163.065*	(89.165)
NG10-14	-0.155***	(0.051)	-78.008	(47.449)
(Compared to NG1)				
IMD	0.029***	(0.003)	3.166	(3.343)
Constant	0.309***	(0.041)	342.296***	(40.695)
Observations	5295		3727	
R^2	0.069		0.027	

Note: Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

The second regression analysis was undertaken to examine the relationships between the

length of time (in days taken) to resolve the cases if the case was resolved and the variables of gender, type of education, ethnicity, location and deprivation.

When results reach the level of statistical significance ($p<0.1$; $p<0.05$; $P<0.01$), we can confidently reject the idea (the null hypothesis) that there is no relationship between the variables that we were testing (Fraenkel and Wallen 2008).

Table 4 shows the results from the regression analysis performed on the data provided by the CME team. In the first model, we regress whether a CME case is solved on a number of demographic variables. Because this outcome variable is binary (solved versus unsolved), the results from the model can be interpreted as simple percentage points. For example, the probability of a case being unsolved is 2 percentage points (pp) higher if the child is female, as opposed to male. However, there is a very large standard error associated with this result and it is not statistically significant. The probability of a case being unsolved is 2.5 pp lower for secondary school students, when compared to primary school students. This result is statistically significant at the 5% level.

We also used the students' ethnicity as an explanatory variable in the model. Because there are a large number of students for which we have no information for, we set this as our base category against which all other groups would be tested. From the results, we can see that the probability that a case is unsolved where the student is white is 11 percentage points lower when compared to cases where there is no ethnicity information for the student. The results for students with Asian, Mixed, or Black ethnicity can be interpreted in a similar way and all of these results are statistically significant. There is no difference in the probability of a case being unsolved between students for which there is no ethnicity information and students from Gypsy, Roma, or Traveler background. If the student's ethnicity is listed as one of the "Other" ethnicities, then the probability that the case is unsolved increases by 9 percentage points.

The students' postcode is also an important determinant of whether the case is solved. Compared to a base category of NG1, the probability of a case being unsolved is lower in almost every other postcode. The exceptions to this are NG2 (where there is no statistically significant difference with NG1) and NG7, where the probability of a case being unsolved is almost 8 percentage points higher compared to NG1. Finally, we also include a measure for the level of deprivation in the local area with the IMD decile. The results show that a move from a lower decile to a higher decile increase the probability that the case is unsolved by approximately 3 percentage points.

In addition to determining whether the case is solved, we can also look at the determinants of case length for the case which are solved. This is the second model that we estimate in Table 4. The explanatory variables that we use are the same as in the first model, but the outcome variable has now changed. We are now looking at the length of time between when the case begins and when the case is closed. Therefore, the coefficients can be interpreted in terms of numbers of days.

Like the previous model, there is no difference between male and female cases with regards to case length. With regards to education level, cases that stem from secondary schools take

almost 27 days longer to solve when compared to cases from primary schools. This is an interesting result considering that the previous model showed that secondary school cases have a lower probability of being unsolved when compared to primary school cases.

The ethnic background variables show a similar pattern to the previous model. When compared to having no information on ethnic background, cases where the student is White, Asian, Mixed, or Black take fewer days to solve. However, there is no statistically significant difference in case length between the group with no information and the Gypsy, Roma, or Traveller group, or the group with the other ethnicities.

The postcode variables also show a similar pattern to the previous models. Compared to the cases that originate in NG1, cases in every other postcode take fewer days to solve. All of these results are statistically significant, except for the cases that originate in NG10 – NG14. However, unlike the previous model, deprivation doesn't appear to affect the length of time required to solve cases.

7. Summary and conclusions

The principal aim of this project was to examine the number and pattern of "children missing education" in the city over a five-year period and to look for insights, patterns and/or trends that might help the CME team (and the council) respond to the changing challenges they present.

Children missing education are difficult to identify; are from heterogenous backgrounds and are often vulnerable with complex social, behavioural, educational, medical, or mental health needs.

There are several suggestions for improvement further work or research within the main text of the report that the team may wish to consider, although we do not intend to repeat these detailed suggestions in this section.

The geographical and demographical analysis in section 2 suggests very clear and relatively stable geographic patterns and trends within the CME cases referred to the team across the city. There is a notable difference (but not statistically significant differences) between the 5-9-year age groups and 10-14-year age groups. The years either side of the transition years from primary to secondary school are peak years for referrals and there is an equally marked pattern of cases across the city where we identified three 'tiers' of case prevalence. Almost inevitably these patterns and numbers are likely to change in the future (not least because of changing migration into and out of the city) but they do provide useful evidence for service enhancement, service deployment (or redeployment) and resource allocation and workforce planning.

The analysis of the characteristics of cases in the city provided in section 3 indicates there are no significant differences between genders nor the pattern of ethnicity, and although the number of cases of *information not obtained* relating to gender have constantly reduced there is some way to go on this issue. This section also looked at referrals by types of school and although initial gross numbers indicated that the number of referrals were increasing from academies and reducing from schools maintained by the Local Authority, this reflects the rising number of academies and the decreasing numbers in LA maintained schools within the city. We would suggest this could most usefully be further investigated at the level of the individual school, although it may not be justified for all schools.

Section 4 looked at the status of cases in the caseload and focused on the outcomes of cases. Of the 5615 cases examined, 71% of the cases had been resolved by the CME team, with 29% open ongoing cases. There is a huge variation in the length of time that it takes to resolve individual cases, but while this is well known to the team this section also revealed and highlighted two factors, which are probably less appreciated by those not directly involved in CME teams. They are the importance of the quality and access to databases (which is largely outside the control of the CME team) and the importance of developing, maintaining and improving networking and collaboration within the city council and across the 'community of interest' that provides the service in local authorities. As almost a quarter of the cases were resolved by the CME team within 7 days, we investigated what kinds of outcomes were achieved to see if they differed from the general caseload and we also looked at the outcomes

and duration of resolved cases in the most deprived areas of the city. In both instances we (reassuringly) found they reflected the general population of all cases.

Section 5 looked at the workforce and its workload. The CME is a relatively small team, as it will be in most local authorities. It works on a very clearly defined on-going task. This section also highlighted the importance of local knowledge and experience in this area of work and the importance of the often 'hidden' skills of trust, reciprocity, perseverance, diligence, and empathy with clients that are essential for the efficient and effective delivery of the service.

Finally, in section 6, we looked at the relationships between cases unsolved, along with the length of time to resolve cases, and the impact of gender, type of education, ethnicity, location and deprivation. The implication is that the factors of the type of education (primary school or secondary school), ethnicity information, location, and deprivation were possibly associated with the probability of whether the case being solved or unsolved as well as the length of time for the case being solved. In particular we found that not only was the likelihood of an unsolved case with ethnicity information (White, Asian, Mixed, or Black background) lower than a case without the ethnicity information, but it also took fewer days for the CME team to resolve the case when the ethnicity information was provided. This might appear obvious, but it does re-emphasise the importance of obtaining the ethnicity information for CME cases.

As stated above there are some detailed suggestions for further investigation or research within the main text of this report. However, in order to significantly advance the strategic knowledge and understanding of the service in the city and elsewhere, we suggest that the team should consider commissioning or undertaking a comparative study of the work of the CME services teams in a small group of authorities.

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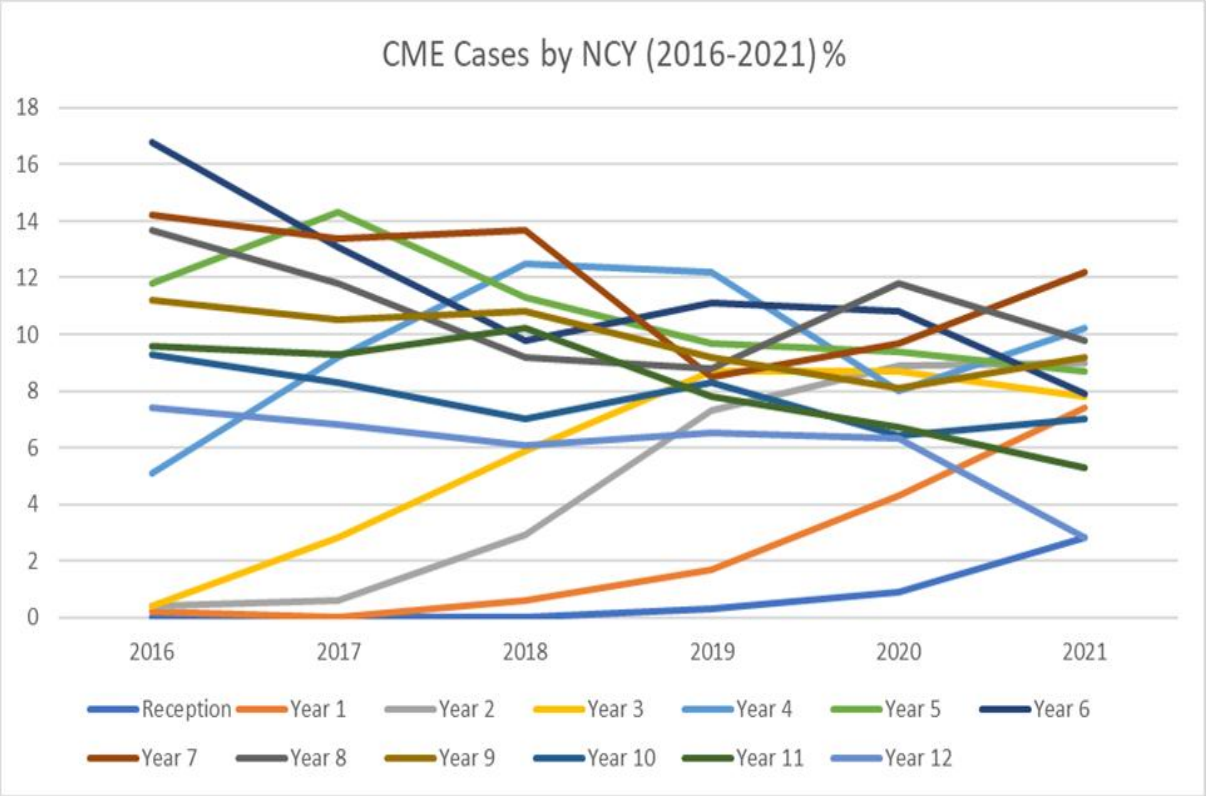
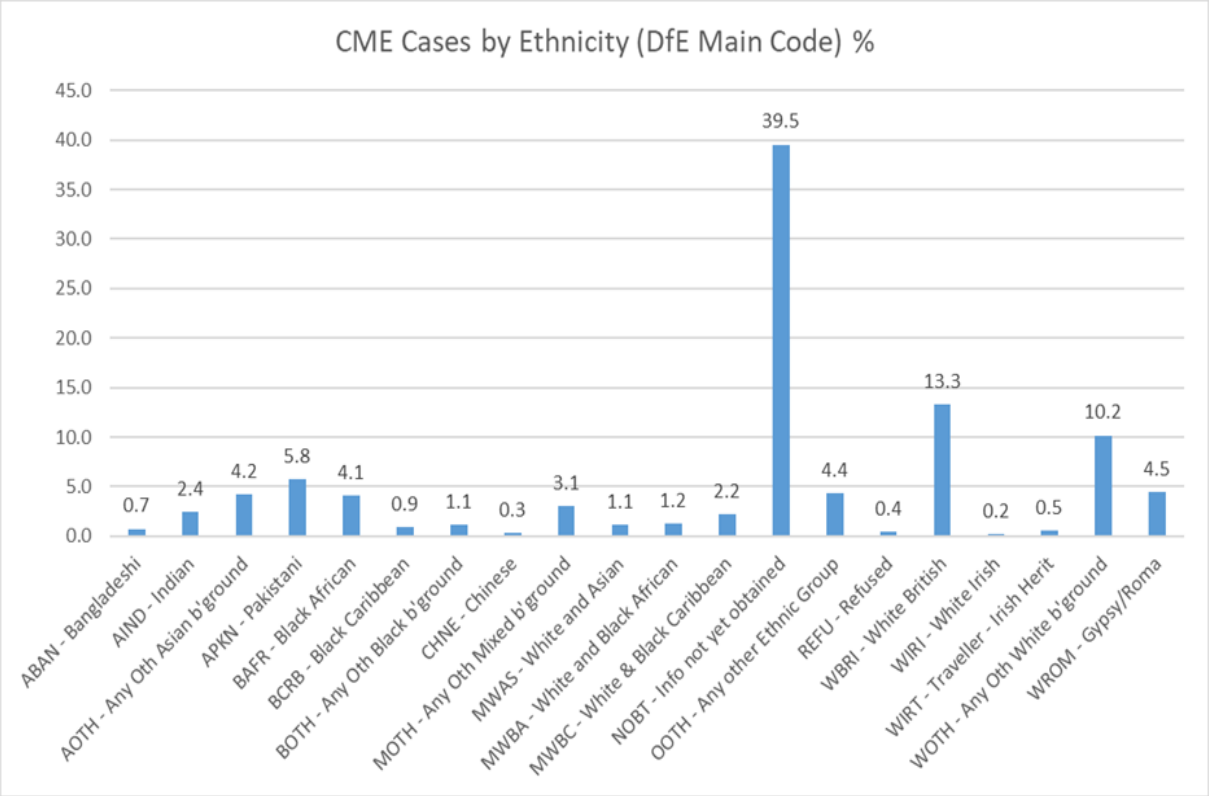
Appendix 1:

CME Cases by NCY 2016-2021 (%)



Appendix 2:

CME Cases by DfE Ethnicity Main Code



Appendix 3:

Trends of the CME Cases by DfE Ethnicity Main Code 2016-2021 (%)