Hounslow Safeguarding Children Board

Annual Report 2014/15

Introduction

The work of the Board for 2014/15 was shaped by the recommendations from the Ofsted inspection of January 2014, which focused on the need for evidence of effectiveness in improving safeguarding services for children and young people.

Child sexual exploitation has had considerable national prominence in the course of the year and the Board has revised its structure to create a dedicated sexual exploitation sub-committee to drive the child sexual exploitation agenda in Hounslow. In this, it has had the explicit support from the Metropolitan Police and the Council and additional resources have been made available to assist in this work.

Additional national guidance has been issued on Female Genital Mutilation and work has been undertaken to strengthen the understanding and identification of female genital mutilation in Hounslow.

A key element of the Board's approach to establishing agencies' effectiveness, individually and collectively, has been the strengthening of the Monitoring and Evaluation Sub Committee of the Board. The work of this sub committee has been greatly supported by the consistent membership of the sub committee which has improved data reporting and the learning from audits undertaken, both within and across agencies.

This report highlights the work of the Board which is dependent on the contributions from partner agencies of the Board, both at Board level and at Sub Committee level.

The Work of the Board

Improving the Functioning of the Board

Ofsted Improvement Plan

This plan was developed in response to the inspection of the Board undertaken in January 2014 which found that the Board 'required improvement'. The plan addressed the specific areas which required to be strengthened:

- Ensure that the LSCB establishes ways to effectively evaluate Safeguarding performance through audit and performance monitoring of multi-agency activity, and this evaluation is used to improve services.
- Ensure the impact and effectiveness of Multi-Agency Safeguarding training is evaluated so that its effectiveness can be assessed and improved.
- Ensure that the issues discussed at Board Meetings are fully analysed and recorded in its minutes and the Annual Report and that this information is used to develop and monitor local plans that demonstrate what measurable impact the Board is having.
- When the LSCB considers that a case may meet the criteria for a Serious Case Review, even if one is not carried out, the Board must check that the Local Authority has notified Ofsted.
- Continue to develop mechanisms to ensure that children and young people can engage with the work of the Board and ensure that all sectors including Faith and wider voluntary groups are represented.
- Increase the influence of the Board by strengthening relationship with other key strategic groups, such as the Health & Wellbeing Board and the Safeguarding Adults Board to ensure that the Safeguarding Children is prioritised.
- Ensure that the work of the LSCB Sub-Committees is effectively undertaken and the work of the Monitoring & Evaluation, Missing & Vulnerable, and Child Sexual Exploitation Groups are influencing practice.

All aspects of the action plan were addressed and a report was submitted to Ofsted to inform them of the actions that had been taken. Ofsted were satisfied with these actions.

Why was this prioritised for the Board?
This was the key driver for the business plan for the year.
What impact did this have?
This strengthened the work of the Monitoring and Evaluation sub committee, ensured that the notification responsibilities of the local authority were being adhered to, and that stronger measure were taken to establish the impact of training on practice.
What follow up action was required?

A follow up report on the implementation of the action plan was submitted to Ofsted and reported to the Board. This demonstrated the effective implementation of the action plan.

Document to Support requests for Serious Case Reviews

This document was developed to improvement the quality of information being presented to the Serious Cases Sub-committee to enable them to make decisions about the need for a case review, and the form of that case review. The document was agreed by the Board and has been in use throughout the year.

Why was this prioritised for the Board?
This was required action in the Ofsted action plan
What impact did this have?
Great clarity about which cases were being considered for serious case reviews as opposed to other forms of review, and assurance that the Local Authority was making appropriate notifications to the Department for Education.
What follow up action is required?
This action is completed and the process embedded in the work of the Board

Resourcing of the LSCB

It had been identified that the Board required administrative support to manage the volume of work. Additional resources were found by Public Health contributing the Board budget and by the Clinical Commissioning Group increasing its contribution and the posts of Board Development Officer and Exploitation and Vulnerabilities Coordinator were able to be established. These posts were recruited to in the course of the year.

Why was this prioritised for the Board?
To increase the capacity available to the Board to support the effectiveness of the Business Manager and to drive forward the agendas in relation to child sexual exploitation and female genital mutilation.
What impact did this have?
This permitted the Board to address policy, training, and practice issues in relation to the vulnerabilities agenda.
What follow up action is required?
The establishing of the Exploitation and Vulnerabilities Coordinator was for two years. The future of the post will need to be considered in 2015/16.

Safeguarding Board Reference Group

To maximise the Board's communication with partner agencies, yet keep Board membership at a manageable number a reference group was established to ensure that there is a two way flow of information from and to agencies that are not directly represented on the Board. The terms of reference of the Reference Group are:

- To inform agencies in Hounslow which are not members of the Board of the priorities and work of the Board
- For the Board to be informed of safeguarding issues as they impact on the agencies of the Reference Group
- To establish routes of communication for the implementation of strategies and policies
- To identify issues to be taken forward to the Board

The Reference Group is held twice a year, and the timing of the second was rearranged to provide an opportunity for the Reference Group to identifies issues to be considered at the Board planning day.

Why was this prioritised for the Board?
To enhance the Board's communication with a wide range of agencies
What impact did this have?
Widened the range of agencies who are looking out for private fostering situations, Early Help pathways being made available more widely, identification of the need for young carers to be involved in the development of transitions pathways, and the role of the Exploitation and Vulnerabilities Coordinator being explained.
What follow up action is required?
There will be two meetings a year with the reference group.

POLICY AND PRACTICE DEVELOPMENT

Female Genital Mutilation

In the course of the year, three multi-agency workshops were held by the Chair of the Board to scope what was known about the incidence of female genital mutilation in Hounslow, and to strengthen the multi-agency response to the identification of the risk of female genital mutilation.

In the course of the year, national guidance had been developed for Health staff and for Education staff and it was established that there was a need to developed pathways within Hounslow to ensure that, in meeting the national requirements of these agencies, there was a coherent response across agencies in Hounslow that was consistent with the London Safeguarding Procedures. These pathways are under development.

Although the Board has been informed of women who have themselves been subjected to Female Genital Mutilation as children in other countries, there have, as yet, been no reports of children or young people living in Hounslow who have been subjected to female genital mutilation.

The Board contributed to the funding of a two year project by Forward to raise parental and agencies' awareness of Female Genital Mutilation in Hounslow, and the Board agreed to establish a Female Genital Mutilation Sub-Committee for the duration of the project.

The annual conference of the Board focused on Harmful Cultural Practices, and this included Female Genital Mutilation.

Why was this prioritised for the Board?
This was identified as a priority for the Board at the Board's Business Planning day because of the identified need to create a greater understanding of FGM in Hounslow.
What impact did this have?
This has strengthened the multi-agency understanding of Female Genital Mutilation and has provided an opportunity to understand the guidance that individual agencies are working with. This has enabled pathways to be developed to manage the flow of information between agencies, while recognising the ethical position of each agency. Work to develop understanding of Female Genital Mutilation is underway by identifying and training Community Champions, establishing a programme of school engagement, and expanding the training programme.
What follow up action is required?
The Female Genital Mutilation Pathways to be finalised and implemented in Hounslow. The regular reporting to the Board of the Female Genital Mutilation Sub Committee on its work to develop family and community understanding of Female Genital Mutilation to maximise the potential for preventing it and identifying it if it has happened.

Neglect

The Ofsted Report on Neglect was reported to the Board and there was an update on the use of the Quality of Care Toolkit across the agencies of the Board. It was reported that the principles of the Quality of Care Toolkit were widely used across agencies, but that form of use differed within agencies, some used the full assessment documentation, others a modified form of the assessment tool to meet individual agency need, and some agencies used the principles for supervision purposes.

Why was this prioritised for the Board?
This was recognised as a priority in the Board's business planning process and national reports were highlighting the need for a greater focus on neglect.
What impact did this have?
The Board re-focused on neglect and was able to be updated by Board agencies on their application of the principles of the Quality of Care Toolkit.
What follow up action is required?
A review of the Quality of Care Toolkit to ensure that it meets the needs of agencies in their assessment processes and to establish the status of the Quality of Care Toolkit within agencies. This will be taken forward in the forthcoming year with the use of the toolkit in Early help to be established.

MASH

It had been established at the time that the Multi-Agency Safeguarding Hub (MASH) was being planned for that the Safeguarding Children Board would oversee its planning and implementation.

The MASH was established in 2013 and was located in Early Help Hounslow. The Board received regular feedback on its operation and it was agreed that an audit would be undertaken to ensure that the threshold for the interface between Early Help Hounslow and Children's Social Care was operating effectively and that decision making in MASH was effective in routing cases in the right direction.

Why was this prioritised for the Board?
MASH is a key mechanism for the early information sharing between agencies to achieve efficiency in the assessment process to ensure children and their families receive the right form of help as soon as possible.
What impact did this have?
This has improved early information sharing between agencies. An audit has established that the MASH has been successful in analysing and appropriately grading referral information.
What follow up action is required?
There is a need for the Board to receive regular and consistent data from the MASH to establish its effectiveness. This is being taken forward in 2015/16.

Children Placed out of Borough

Why was this prioritised for the Board?
Children placed out of Borough are considered to be more vulnerable because of the distance from their families and community, and because of the lack of continuity of education and health provision.
What impact did this have?
Greater understanding by Board agencies of the numbers of children placed out of Borough. A recognition that some children and young people are placed out of the Borough for good reasons, to access specialised resources or to be with family members, while some may be placed out of Borough because of the lack of capacity of placements within the Borough. Children's Services confirmed that their strategy is to increase capacity within the Borough to meet the needs of children and young people. The data presented to the Monitoring and Evaluation sub committee shows that more children are now being placed in Borough, and young people report that they welcome placements that are closer to their families.
What follow up action is required?
Data on children's placements to identify those placed out of Borough to be reported to the Monitoring and Evaluation Sub Committee. The Chair of the Board to discuss children placed out of Borough with the Independent

Reviewing Officers.

Operation Concordia

The Metropolitan Police reported Operation Concordia to the Board. This included a review of gang activity amongst teenager in the Borough. Although some London Borough have designated 'gang Borough' status and accrue additional funding because of that, Hounslow does not fit into that category. The incidence of gang involvement amongst young people in Hounslow falls below the threshold for 'gang Borough' status, but there is an emerging problem in relation to gangs in the Borough.

The Concordia project seeks to provide mentors for young people who are considered to be at risk of being drawn into serious crime and gang culture.

Why was this prioritised for the Board?
This was prioritised because of a serious local gang related incident and to understand the extent of gang activity in Hounslow.
What impact did this have?
The Board was informed of the extent of gang activity in Hounslow, the training available to staff in Hounslow on gang related activities, and the role of the Concord Police Officer in engaging with gangs. Coupled with the audit of a gang related case, this strengthened agencies' understanding of the resources available to respond to the identification of gang affiliation. Information to Board agencies on how to refer into Operation Concordia was provided.
What follow up action is required?
Yearly up-date on the understanding of gang related activity in the Borough to enable the Board to assess the impact of this Operation.

Child Sexual Exploitation

Child sexual exploitation had been managed in the Missing and Vulnerable Sub Committee of the Board, but in light of the concerns arising from National serious case reviews, the Children's Commissioner and Ofsted, a dedicated sub-committee of the Board was established to manage the magnitude of the task. This sub committee is chaired by the Chair of the Board.

On publication of the Rotherham report into sexual exploitation, a special joint meeting of the Missing and Vulnerable Group and the Monitoring and Evaluation Sub Committee of the Board was held to review the recommendations from the review. Many of the recommendations had already been addressed in Hounslow, but there were additional items that were identified and an action plan was developed to strengthen the response to child sexual exploitation in Hounslow.

This action plan was incorporated into a Partnership Improvement Plan which addressed actions arising from the Peer review into sexual exploitation, the review of MASE across, recommendations from the Children's commissioner, and ultimately the review by Manchester Police of sexual exploitation in the Greater Manchester area.

As a result of the review of the recommendations from the Rotherham report, the Local authority funded an Exploitation and Vulnerabilities Coordinator to drive forward the plans to strengthen the prevention and response to child sexual exploitation in Hounslow.

The work of the Board to address child sexual exploitation has been greatly supported by the commitment of the Chief Executive, the Borough Commander, and the Director of Children's Services who supported the London wide Operation Makesafe initiative by the Metropolitan Police, but who also supported a parallel local initiative in Hounslow to ensure that the Business Community understood the risks of child sexual exploitation and their role in providing intelligence to the Police.

The local response to Operation Makesafe was coordinated by the Board. The need to maintain links with the Business Community and the Faith Communities in Hounslow was recognised and this will be taken forward by the Sexual Exploitation Sub Committee.

The terms of reference of the Sexual Exploitation Sub Committee were revised and agreed.

It was agreed to seek membership from schools, the NSPCC, Public Health.

It was agreed to established integrated data for the Board on child sexual exploitation.

The Chair of the Board reports regularly to the Health and Wellbeing Board on child sexual exploitation in Hounslow and child sexual exploitation has been added as a standing item on the Health and Wellbeing Board's agenda.

The first meeting of the Sub Committee recognised the need to extend the membership to schools, Public Health, and to the NSPCC.

Why was this prioritised for the Board?
Child Sexual Exploitation is both a local and national priority
What impact did this have?
The child sexual exploitation assessment processes have been strengthened, the multi-agency overview of cases at strategic and operational level has been strengthened, there is better use of data to understand the incidence and nature of child sexual exploitation in Hounslow, there is specific sexual exploitation training provided by the Board, there is a developing focus on the prevention of child sexual exploitation in primary and secondary schools.
What follow up action is required?
The Child Sexual Exploitation Sub Committee will develop and oversee action plans to strengthen the recognition of child sexual exploitation and the response to those young people who are identified as at risk of exploitation. This will be on-going work of the Board.

This will include improving the collection and use of intelligence information, better integrated data to inform prevention, the more consistent use of dedicated assessment processes, improving feedback from young people to better understand the local nature of child sexual exploitation and how best to target prevention.

Private Fostering

The annual report on private fostering was reported to the Board. The rate of identification of private fostering remains low, in spite of efforts by Children's Social Care and other agencies to raise the profile of private fostering.

It was clarified that private fostering is covered in Board Safeguarding Training and that information has been made available to all agencies.

It was recognised that there is limited dedicated capacity to promote the recognition of private fostering and that all agencies need to ensure that their staff understand what private fostering is and the need to refer to Children's Social Care when a young person is identified as living in a private fostering situation.

It was agreed that information on private fostering would be again distributed to the agencies of the Board, lead professionals would be identified in all agencies to promote an understanding of private fostering.

Why was this prioritised for the Board?
The oversight of private fostering is a specific responsibility of the Board
What impact did this have?
A re-invigoration across agencies of efforts to understand, report, and support private fostering.
What follow up action is required?
For the Board to be updated on the effectiveness of the plan and to receive the annual report on private fostering.

Self-harm and Suicide Prevention

The Chair of the Board undertook a scoping workshop with agencies of the Board to establish what was currently in place to identify and support young people with self-harming behaviours. It was established that those agencies that had received training and support on self-harming behaviours were proactive in providing and seeking support for young people, leading to a reduced referral rate to tier 3 CAMHS services. Some schools had commissioned counselling services and this provided speedy support for young people, and contrasted with those young people who, if there was not a commissioned counselling service, had a waiting list for counselling support.

It was also identified that the Pathway for young people with self-harming behaviours attending A&E could not always be followed because of competing demand for paediatric beds.

Why was this prioritised for the Board?
There has been on-going work in Hounslow to address self harm following a serious case review, and this scoping exercise was undertaken to assess the impact of the training and support that has been provided in the Borough.
What impact did this have?
Greater support has been provided to young people when training has provided staff with the confidence to address the issues.
What follow up action is required?
1 The self harm pathway at A&E to be reviewed 2 The experience of a school that has fully engaged with the task to be evaluated and reported throughout the school network **3** The Board to maintain self-harm as a priority for 2015/16

Health Visiting Needs Assessment

In preparation for the Health Visiting service transferring to the Local Authority, a review has been undertaken by Public Health. This review found that to be able to meet the level of demand 12 additional posts require to be recruited, only 8 of which currently are funded.

There is on-going discussion on the funding of the service and this will continue prior to the responsibility for the commissioning of Health Visiting being transferred to Public Health.

The assessment also highlighted that Health Visitors were seeking greater clarity about the process for managing concerns about Female Genital Mutilation.

Why was this prioritised for the Board?
The Board wished to be informed the planning and arrangements for the transferring of the commissioning arrangements for Health Visiting.
What impact did this have?
Concerns were raised about the ability to recruit the number of Health Visitors to meet the level of need in Hounslow.
What follow up action is required?
Further reporting to the Board on the resolution of funding transfer to Public Health and updating on the ability to recruit to Health Visiting Posts.

Elective Home Education

It was reported to the Board that, following the previous discussion at the Board when it was identified that there was insufficient capacity to provide a good service to children who were home educated, the Schools Forum agreed funding at the end of 2013 to enable the service to be developed. This came from the Direct Schools Grant. The impact of this was

reported to the Board and the service was able to demonstrate increased effectiveness in returning children and young people to school, as well as provided greater contact and support to children being home educated.

The Board was informed that the increased funding was temporary and the Board asked to be informed if the current capacity in the service could not be maintained.

Why was this prioritised for the Board?
This has been a continuing focus of Board attention for a number of years, and it had been agreed that there would be year updates to the Board on the support provision for young children and young people who are home educated.
What impact did this have?
The increased funding has provided additional capacity to identify and support families leading to a greater return rate to school.
What follow up action is required?
There will be a report to the Board on elective home education in 2015/16

Regulation 85 Children Placed out of Borough

The additional vulnerability of children placed out of area has been emphasised in national reports, especially in the context of child sexual exploitation. The Department for Education recently reinforced the need for local authorities to give particular attention to the needs of children placed away from their home area and to ensure that there is notification to the host local authority of the child's placement in their area.

It was reported to the Board that in Hounslow and across London there has been work to improve the notification of young people who have been placed out of area. It was also reported that there is activity underway to try to increase the number of foster placements available in Hounslow to reduce the demand for out of Borough placements.

Why was this prioritised for the Board?
It was recognised that this is a more vulnerable group of young people and placing out of Borough can complicate access to health and education services.
What impact did this have?
Supported the strategy to increase the number of placements available in Hounslow.
What follow up action is required?
1 The reporting of the number of looked after children placed out of Borough to the Monitoring and Evaluation Sub committee **2** The chair to establish a forum for private providers in the Borough.

Use of Bed and Breakfast Accommodation

Housing Services were asked to report to the Board on their use of Bed and Breakfast accommodation for families with children. It was reported that the current standard of families with children not being in Bed and Breakfast accommodation for more than 60 days

was being achieved. It was also confirmed that Housing Services check on the suitability of placing families within Bed and Breakfast accommodation in relation to whom they know is also placed there. It was recognised that Housing Services only have information about who they have placed in the accommodation, and do not have information about who is placed there by other local authorities.

Housing Services reported that their access to suitable accommodation in the Borough can be limited by other local authorities also placing in the Borough, in accommodation that is cheaper in Hounslow than in the home local authority area. Housing Services have developed a strategy to increase their access to local accommodation.

It was confirmed that Housing Services do not have any single under 18s in Bed and Breakfast accommodation.

Why was this prioritised for the Board?
To provide information to the Board on the use of Bed and Breakfast accommodation and its impact on children and families.
What impact did this have?
Alerted Board members to the difficulties faced by families living in Bed and Breakfast accommodation and provided information to agencies on who to contact to discuss concerns about families.
What follow up action is required?
It was recognised that there was a need to follow up on the use of Bed and Breakfast by: • Asking Housing Services to update the Board in six months' time on the placement of families in Bed and Breakfast • Considering the use of Bed and Breakfast for families that have no recourse to public funds • Considering the use of Bed and Breakfast for care leavers

LEARNING AND IMPROVEMENT

Peer Audit on Sexual Exploitation

A Peer Audit was undertaken in conjunction with Harrow and Enfield to consider how well Hounslow agencies were dealing with child sexual exploitation. This found that services for sexually exploited young people were established in Hounslow, but that they could be strengthened by:

- The more consistent use of the Hounslow Risk Assessment Tool
- Better use of local intelligence
- Development of a local data set for analysis

- Stronger links between MASE and MASH

The recommendations from the Peer Audit were included in the Partnership Improvement Plan whose implementation is being overseen by the Sexual Exploitation sub committee.

Why was this prioritised for the Board?
Sexual exploitation is both a local and national priority
What impact did this have?
This provided the evidence to identify where to focus attention within Hounslow on strengthening the process to better assess the needs of young people who are at risk of sexual exploitation. The peer review informed the Partnership Improvement Plan.
What follow up action is required?
Through the Child Sexual Exploitation Sub Committee oversee the implementation of the Partnership Improvement plan and to report progress to the Board.

Serious Incident Action Plan

The Board received information about the murder of a young man in the area where there were concerns about the attack being perpetrated by young men who had been looked after in local Boroughs and there was concern that the incident may have arisen out of gang rivalry.

Local agencies quickly established an action plan based on the information arising from the incident. The plan and its implementation were reported to the Board.

The incident was also referred to the Board's Cases sub committee and a case review was commissioned with an independent reviewer. This review will be reported to the Board in 2015/16.

Why was this prioritised for the Board?
This addressed the needs of older young people from a multi-agency point of view, who were at risk of gang affiliation or of engagement in serious youth crime.
What impact did this have?
The Risk of Harm Panel was established to consider the needs of young people who are identified as at risk because of gang affiliation or of engagement in serious youth crime. The early data indicates a reduction in the numbers of young people identified as becoming involved.
What follow up action is required?
The work of the Risk of Harm Panel will be reported to the Board.

Early Help Hounslow Audit

This audit was undertaken jointly by Early Help Hounslow and Children's Services. It reviewed 60 cases.

The audit found:

- That the practice was safe
- The majority of referrals were assessed with 24 hours
- Case that needed referral to Children's Social Care were done in a timely fashion.
- 2 cases were identified as being delayed and action taken to remedy.

Why was this prioritised for the Board?
To establish if the threshold document is being applied in a consistent fashion.
What impact did this have?
An action plan to strengthen practice, including: • Revising the threshold document • Reviewing expected timescales • Ensuring there is documented management oversight • Workflow process to be reviewed • Embedding quality assurance process A review of Early Help Hounslow is also being undertaken.
What follow up action is required?
Report to the Board on the implementation of the action plan

Learning from Multi-Agency Case Review

A case of neglect was reviewed by the Cases sub committee to establish how well agencies were working together in the area of neglect to promote the health and wellbeing of children.

The key findings from the audit were:

- Statutory intervention should always be considered
- Family history should be fully understood
- The Quality of Care Toolkit to be embedded into practice
- Improved core group functioning
- The use of the escalation policy
- The development of a relationship with the children
- The engagement with GPs

Why was this prioritised for the Board?
To establish if there was learning about how neglect cases were being managed across the professional network
What impact did this have on service provision?
The Quality of Care Toolkit is being refreshed There has been better engagement with GPs There has been better working with mobile families who cross Borough Boundaries.
What follow up action is required?
Neglect has been recognised as a priority for 2015/16 and this will include the scoping of the use of the Quality of Care Toolkit and agreed its status within agencies.

STRATEGIC LINKS

Children and Young People's Strategy

The review of the Children and Young People's strategy was presented to the Board. Board agencies had already had the opportunity to contribute to its revision. The Board supported the revised strategy which will be presented to the Health and Wellbeing Board.

Why was this prioritised for the Board?
This is the key strategic document that provides focus and drive for the agencies of the Borough to address the prioritised need of children and young people.
What impact did this have?
The Board's support of this document ensured the integration of strategic bodies across the Borough in meeting the safeguarding needs of children and young people.
What follow up action is required?
The Board's business planning taking account of the strategy, and the Board identifying any factors that may lead to the future development of the strategy.

Links with Public Health

It was identified at the Business Planning day in March 2014 that there was a need for the Board to strengthen its links with Public Health. There is now a Public Health representative on the Board and are engaged in the Child Death Overview process, Health Visiting, School Nursing, and the developments in relation to Female Genital Mutilation in the Borough.

Why was this prioritised for the Board?
Public Heath has is now located in the Local authority and key safeguarding services like School Nursing and Health Visiting will be commissioned by Public Health
What impact did this have?
This has strengthened links with Public Health.
What follow up action is required?
The links have been established. Future action will be in accordance with their membership of the Board.

The use of agency staff within agencies

All agencies of the Board were asked to complete a template to assist discussion on their use of agency staff to establish if there were any vulnerabilities for children and families from the use of agency staff. All agencies reported the use of agency staff, but all reported that the numbers of agency staff within their agency had not caused an imbalance in their workforce and that training and supervision were made available to agency staff as for permanent staff. Agencies were asked to report on any emerging vulnerabilities to subsequent Board meetings under the Board agenda item 'Capacity Issues and Organisational Change'.

Why was this prioritised for the Board?
For the Board to be assured that the implications of the use of agency staff were understood by agencies, individually and collectively, and to establish if agency staff were accessing required training and supervision.
What impact did this have?
The Board was able to establish that all agencies are using agency staff, but that they are able to access appropriate training and supervision.
What follow up action is required?
For all agencies to report to the Board under the standing agenda item of 'Capacity and Organisational Change' if there is a substantial change to the use of agency staff, especially if there is concern that there may be dis-continuities in the provision of service.

Endorsement of NHS information Sharing

The Board received information about an initiative to strengthen the flow of information about children who were looked after or had a child protection plan who were attending A&Es throughout the country.

Why was this prioritised for the Board?
This was a national initiative that required Board approval.
What impact did this have on service provision?
This has not yet been implanted for Hounslow children.
What follow up action is required?
The Board to be informed when the project goes live in Hounslow.

The Sub-Committees of the Board

Monitoring & Evaluation Sub-Committee Report 2014/15

The Monitoring and Evaluation Subgroup grew in relative strength and prominence throughout the course of the year (2014-2015). Membership of the group was stable and consistent with significant amounts of data coming into the subgroup from the partnership. Such data included data from the MET Police on crime and child abuse, performance data from Children's Social Care and specialist services; and some data from Early Help Hounslow (EHH) including a data set from the Multi-Agency Safeguarding Hub (MASH).

Along with this hard data, the subgroup also identified key information on practice standards gained through routine auditing within each agency. Whilst it isn't yet embedded in a consistent way, there is nevertheless more evidence of audit work being analysed through the Monitoring and Evaluation Subgroup throughout the course of year. On one occasion a key audit (August 2014) was commissioned around the Child Protection (CP) Case Conference process, quality of the CP Plans, the activity of the Core Group and the structure of the Review Conference. As a result of this audit, the learning demonstrated a need for a change in the Practice guidance around Core Groups; and the manner in which Child Protection Plans are reviewed at Review Conferences.

Other key audits undertaken during the year included a deep dive audit into Early Help Hounslow particularly looking at the 'front door' and the interface between Early Help and specialist services. The findings from the audit helped to prompt a general review of Early Help, and its overall impact on specialist services.

Other audit activities include a deep dive of a single complex multi-sibling family, which was examined at a learning event attended by 10 different partner agencies (June 2014). This audit identified some key learning around engagement with GP's and having a more consistent approach to the assessment of chronic neglect; for multi-sibling families with significant health and complex social problems.

The cross over between children's and adults services was also explored through the commissioning of a themed audit into parental mental illness, parental substance misuse and parental learning disabilities as well as domestic abuse; and its impact on the welfare of children. This themed audit will be reported on in the autumn of 2015.

Work completed by the sub-committee in 2014/15

- Presentation of data set and analysis for the Police in its investigation of Child Abuse (July 2014), and allied crimes against children.
- High level learning of a single complex case and its implications for practice around Neglect and engagement of GP.

- Audit information related to Early Help Hounslow – “is the front door safe?”
- Audit of Child Protection Case Conferences and Core Group activity.
- Identification of the need for themed audit into cross over issues with Adults Services especially parental mental illness, parental substance misuse, learning disability and domestic abuse.

Ongoing work for 2015/16

- Further development of routine audits being presented at the ME group on an ongoing basis from across the partnership.
- Themed audit into parental mental illness etc. still to report and be completed.
- Data set relating Early Help Hounslow, MASH etc. to be consolidated.
- Quality Assurance framework in relation to Early Help Hounslow to be more embedded and routinely reported into the ME subgroup.

Priorities for 2015/16

- Learning from audits to be further consolidated and with more analysis being done at the ME subgroup.
- More analysis of performance information with better quality information on trends to be presented to the Main Board meeting.

Issues regarding the functioning of the sub-committee

- The timing of the data cycles has made it difficult for the ME subgroup to be consistent about analysing performance information, some of which can be at least 6 months in arrears by the time it is presented to the Main Board.
- Fuller engagement from Early Help Hounslow in terms of presenting quality assurance information; and better use of information from service users and complaints to be incorporated into the ME subgroup.
- There needs to be a Vice-Chair for the ME subgroup to ensure resilience within the operation of the group; and to ensure continuity.

Missing & Vulnerable Sub-Committee Report 2014/15

During the first part of the year (2014) the Missing & Vulnerable (MAVS) Subgroup devoted much attention to the work associated with Child Sexual Exploitation (CSE). On a national level there were a number of Serious Case Reviews (SCRS) published which raised Child Sexual Exploitation to a high profile level with high numbers of children seemingly being exploited. This eventually led to the establishment of a bespoke Child Sexual Exploitation Subgroup but this was not until the very end of the year (March 2015).

The MAVS Subgroup also devoted a significant amount of time scanning and assessing the national landscape relating to other forms of vulnerability such as female genital mutilation (FGM). This in itself required bespoke work streams around the mandatory reporting of FGM in the local area of Harrow; and also the development of pathways around how this should be managed and assessed.

During the course of the year (2014-2015), the MAVS Subgroup identified issues relating to data recording for Child Sexual Exploitation, FGM, as well as Missing Children and these were all addressed through various work streams in the group during the course of the year.

Most importantly the practice around assessing risk in relation to these emerging vulnerabilities grew in prominence in the group. The group helped to support the peer review into Child Sexual Exploitation in conjunction with two other Local Authorities (Harrow and Enfield). As part of this peer review the creation of risk assessment tools and their use in practice, was an area of development noted by the independent auditor and which took up a lot of time for the MAVS Subgroup.

Work completed by the sub-committee in 2014/15

- The Missing Children 'grab pack' was trialled and implemented via the MAVS Subgroup. This was a collaborative piece of work undertaken with the MET Police and focussed primarily at The Ride children's home. In essence, the 'grab pack' is a 'bundle' of up-to-date key biographical information which could be 'grabbed' at the time when a young person is reported missing or deemed to be at risk of harm because of unauthorised absence.

- The recording of data around missing children was also progressed through the MAVS Subgroup. This included particular attention given to the repeat episodes of children going missing from children's homes within the Borough but also from other placements. This work continues to be a high priority and will need to be strengthened in relation to out-of-borough placements; and all looked after children, as well as children who run away from their family home.

- All aspects of children being reported missing were covered by the MAVS Subgroup during the year; including children missing from education where they might be at risk or vulnerable for other reasons.

Ongoing work for 2015/16

The work around the 'grab pack' still needs to be consolidated and rolled out across other types of placement settings; particularly children who are placed in private provider settings within the Borough, who would be ordinarily reported missing to the local borough Police in Hounslow.

Similarly, the roll-out of the 'grab pack' with in-house foster carers and residential units where children are particularly at risk out-of-borough, is an ongoing piece of work which has been carried over into the next year.

Priorities for 2015/16

The institution of the Modern Slavery Act 2015 (March 2015) will no doubt result in greater emphasis on the need for children at risk of trafficking to be more consistently identified and assessed. This will need to be a priority of the MAVS Subgroup in the coming year; with particular emphasis on the need to make use of the national referral mechanism (NRM) for reporting suspicion of child trafficking to the UK Human Trafficking Centre (UKHTC).

Issues regarding the functioning of the sub-committee

Overall, the MAVS Subgroup is well attended by relevant professionals from across the partnership. It will be particularly important to have close working relationships with the Early Help Hounslow services and full integration with the Multi-Agency Safeguarding Hub. This will be especially important in terms of data collection and using this information analytically to help demonstrate improvements in practice; around raised awareness around the different forms of vulnerability which are emerging in the local community.

Cases Sub Committee Annual Report 2014/15

Work completed by the sub-committee in 2014/15

Notification Process

Documentation was developed to support agencies in proposing cases to be reviewed by the sub committee. The documentation was structured to assist the sub committee to decide if the threshold for a serious case review was established or if another form of review was required.

Consideration of different types of review

The sub committee engaged with a consultant to consider different forms of review and the methodologies that could be followed. This was aimed at finding the right form of review for the particular circumstances of the case.

Jimmy Savile investigation

In the context of the national review of cases that were linked with Jimmy Savile, Hounslow was asked to review a case of an allegation in what is now a closed children's home. The sub committee established a strategic group to oversee the review. Because of the passage of

time, there was limited information available for the review and no recommendations arose directly from the review.

Review of Family C

The sub committee undertook a review of Family C to establish if, in the complex circumstances of the case, there was any learning about how agencies worked together to identify and respond to neglect.

The learning form the case was that there was a need to refresh the Quality of Care Toolkit to support the assessment of neglect, and that there was a need to ensure that General Practitioners were more integrated into multi-agency working. Further work to support this has been taken forward by the Board.

Decision to undertake a serious case review

The sub committee recommended that a case be taken forward as a serious case review. This was agreed by the Chair of the Board. The review will report in 2015/16.

Review of a teenage fatal stabbing

A review was commissioned into this and will report in 2015/16.

Work Underway 2014/15

The serious case review panel was established and the review is underway.

The review of the fatal stabbing is being finalised.

Priorities for 2015/16

To finalise, publish, and implement recommendations from the serious case review.

To undertake a review of a case which demonstrates good practice.

To capture the learning from case reviews elsewhere.

The functioning of the Sub Committee

There has been good and consistent attendance by agencies at the sub-committee.

A new chair was appointed to the Sub Committee from Health.

The Child Death Overview Panel Manager joined the sub committee to strengthen links between the Cases sub committee and the Child Death Overview Panel.

Female Genital Mutilation Sub-Committee Report 2014/15

Work completed by the sub-committee in 2014/15

During 2014-15 Community Safety led on securing funding from the LSCB, Community Safety Partnership and Health & Well Being Boards to fund a dedicated project to address FGM in Hounslow. The project is being delivered over 24 months from November 2014.

The sub-committee was specifically to set up to overlook the delivery of the project, which is being delivered by FORWARD (Foundation for Women's Health Research and Development).

The sub-committee agreed its Terms of References and a 12 month action plan, which consists of:

1. Develop and deliver a Community Champion programme to challenge communities known to practice FGM.
2. Develop a sustainable education programme in schools, similar to the model adopted by the Learning to Respect, Domestic Violence Education Programme.
3. Provide training to Hounslow professionals
4. Develop referral pathways.

One training session has been delivered to 21 professionals via the LCSB training programme.

11 residents have been recruited to be part of the Community Champion programme and are attending the training sessions.

11 professionals have agreed to part of the multi-agency team, who will support the delivery of the FGM prevention work in schools. These professionals will train teachers on the various ways this work can be delivered in a classroom setting.

Other work includes:

More than 30 women signed up to receiving news and information from FORWARD at the borough's International Women's Day.

Presentation delivered to Brook at their quarterly forum

An awareness session delivered to the Young People & Teenager Pregnancy Forum

An information session delivered to the National Union of Teachers in Hounslow

Four men successfully recruited from a session focusing on engaging Somali men to speak up about the harms caused by FGM.

Ongoing work for 2015/16

To continue to deliver the 12 month action plan.

Priorities for 2015/16

To continue to work on the established programme.

Issues regarding the functioning of the sub-committee

There are currently no issues affecting the functioning of the sub-committee. It is worth mentioning, the project is only funded until November 2016.

Child Death Overview Panel Sub-Committee Report 2014/15

The Child Death Overview Panel (CDOP) is a Joint Subgroup of the LSCBs for Hounslow, Kingston and Richmond. Through a comprehensive and multidisciplinary review of child deaths, the CDOP aims to better understand how and why children in the London Borough of Hounslow, Royal Borough of Kingston upon Thames and the London Borough of Richmond upon Thames die and use the findings to make appropriate recommendations where possible to prevent further child deaths.

Work completed by the sub-committee in 2014/15

The CDOP Chair rotates on an approximately annual basis between the three boroughs' respective representatives from Public Health. As of February 2015, the current CDOP Chair is Hounslow's Public Health Panel member.

The CDOP met 6 times during 2014-15. The CDOP held an annual neonatal focused panel meeting which was attended by guest experts from a range of relevant disciplines from both local and tertiary hospitals. An annual development session was held in February 2015 at which the CDOP had a presentation and question and answer Session with two Paediatric Pathologists. This has enriched the panel's understanding of post mortem processes significantly. Representatives from the panel also met with the local Coroner and this has helped to develop and strengthen this key relationship.

The panel completed the review of twenty-two deaths of children resident in Hounslow during 2014-15. Of these, ten were judged to have modifiable factors; these are factors defined according to Working Together 2015 as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. Over half of these deaths were subject to internal Serious Incident Investigations at the relevant hospital trusts; the panel were assured in these cases that comprehensive learning and appropriate action plans had been generated.

Eight of the deaths reviewed were subject to coronial investigations including Coroner's post mortem examinations and in some cases, an inquest. Any learning points identified by the

panel additionally to learning from internal reviews and inquests, have been fed back to the relevant agency. The panel has also begun copying in corresponding LSCBs, where the agency is out of area.

Across the reviews conducted, both amongst those deaths of Hounslow children considered modifiable and non-modifiable, some themes are present as follows:

- Difficulties in effectively engaging and supporting a diverse multi-ethnic and multi-cultural community with respect to their health needs and appropriate access to services
- The need for quality and consistency of record keeping and the importance of documenting clinical decision making within and between hospital trusts
- Capacity within health services including availability of neonatal and acute transport services, availability of intensive care bed spaces, and of obstetric theatres at local hospitals.
- The need for timely palliative care planning

Outcomes of reviews are reported by the LSCB to the Department for Education (DfE) on an annual basis by the end of May each year. Issues arising from local case reviews that may have national significance are raised for the DfE's consideration therein.

The CDOP will provide a detailed Annual Report on 2014-15 with recommendations to the LSCBs and a CDOP work-plan in due course. The recommended work will be based on the themes identified from case reviews across the three boroughs including those outlined above.

Ongoing work for 2015/16

The CDOP provides an Annual Report to the LSCBs which this year was received by Hounslow LSCB in November 2014. An action planning meeting was held to address the recommendations made to the LSCB and the following was agreed:

- Public Health are to report to the LSCB on whether awareness-raising amongst those for whom there may be language and cultural barriers to appropriate access emergency and other services, is reflected in the Joint Strategic Needs Assessment and Public Health Annual Action Plan.
- LSCB member agencies are to be surveyed on provision of interpreting and translation services in cases of both planned and urgent contacts with families and best practice principles in place. This will be facilitated as a one-off audit and on an ongoing basis in conjunction with the section 11 audits.
- The Designated Paediatrician for child deaths in Hounslow is to clarify what information is currently provided to member of the public considering IVF treatment particularly with respect to the number of embryos recommended for transplantation.
- Information is to be sought from the Local Authority's Road Safety Team as to campaigns currently in place targeted to children and young people's safety on the road.
- Public Health is to report to the LSCB on any current work in relation to consanguinity in the borough.

- Local services will present to the LSCB on their strategy and work on addressing substance misuse in children and young people, as well as their parents and carers.
- The LSCB is completing a scoping exercise, working towards identifying which agency will develop the suicide prevention strategy.
- Local bereavement services are to be clarified with Hounslow CCG and promoted via the CDOP in their communications with families and professionals.
- The Named GP for safeguarding to report on GP engagement with child death review process including any recommendations for improving processes to support their participation.
- The Assistant Director for Education and Early Intervention will report on preparedness of education sector for responding to critical incidents.
- The board will seek assurances that pre-birth child protection conferences are held in a timely way in accordance with risk.
- Executive summaries of the CDOP Annual Report will be produced and agreed by the board for publication at the time of the report being presented.
- A CDOP newsletter was issued and shared amongst board member agencies. A newsletter will be produced henceforth on a biannual basis, to promote learning from child deaths locally.

Between 1st April 2014 and 31st March 2015 the CDOP was notified of nineteen deaths of under 18 year olds resident in Hounslow; this is the lowest number of deaths reported annually since the child death review process began in 2008. Ten of the deaths in 2014/15 were unexpected. An unexpected death is defined as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to death. The deaths from 2014-15 will be reviewed as soon as possible during the course of 2015-16.

Priorities for 2015/16

A key priority for the CDOP is Improve timeliness of completion of case reviews. The aim of the CDOP is that other than in cases of unavoidable delay, such as those deaths subject to inquest, serious case review etc. all deaths be reviewed within six months of occurrence to ensure that any learning identified is acted upon promptly. Two extraordinary Hounslow only CDOP meetings have been scheduled for 2015 to improve the timeliness of case review completion. There have also been changes implemented to the way that information is circulated, summarised and reviewed, which should improve the efficiency of the panel.

Alongside this the CDOP will seek to complete the 2015/16 work-plan once agreed.

Issues regarding the functioning of the sub-committee

As noted, the CDOP have a plan in place to reduce the number of cases awaiting review.

Child Sexual Exploitation Sub Committee Report 2014/15

Work completed by the Sub Committee in 2014/15

The sub-committee was established in March 2015. Prior to that date the Missing and Vulnerable Sub-Committee addressed issues of child sexual exploitation, but in recognition of both the importance of the issue of child sexual exploitation and the magnitude of the concerns as expressed by national reviews of responses to child sexual abuse, issues raised nationally by Ofsted, and the report of the Children's Commissioner The Board agreed that a dedicated sub-committee of the Board would be established to drive forward work across all agencies in relation to child sexual exploitation.

The terms of reference of the Sub Committee were agreed as:

1 To receive and analyse data on child sexual exploitation in Hounslow

2 To oversee the implementation of the Partnership Implementation Plan (Sexual Exploitation)

3 To oversee child sexual exploitation training in Hounslow

4 To develop and maintain a communications policy on child sexual exploitation

5 To develop an understanding of the capacity needs across agencies in Hounslow to respond to the developing level of demand

6 To establish if there is sufficient capacity is services to meet the short and long term needs of the young people who are exploited

7 To ensure that strategy and policy developments impact on the quality of the provision of services to young people

8 To ensure that there is clarity about the governance of strategies and services to combat child sexual exploitation in the Borough, and to use the governance structure effectively to drive service improvement

9 To be informed of emerging national issues in relation to child sexual exploitation

10 To report regularly to the Safeguarding Children Board

11 To contribute to the Business Plan of the Board

12 To contribute to the annual report of the Board

Priorities for 2015/16

- To establish integrated data for the Board
- To maintain the community focus of Operation Makesafe
- To establish preventative programmes for children and young people
- To seek the views and learn from young people who have received services
- To continue to learn from local and national experience
- To scope the availability of therapeutic services to meet the needs of young people in Hounslow
- To establish if services for young people who have been sexually exploited are meeting their needs
- To increase family, community, and professional awareness of child sexual exploitation

Issues regarding the functioning of the sub-committee

The inaugural meeting of the sub-committee established that the there was a need for wider representation and this has been achieved.

Training Sub Committee Report 2014/15

Work completed by the Sub Committee in 2014/15

This year we delivered an increasingly varied programme of learning events including two seminars and we planned our annual conference about gaps between adults and children's services. We have collaborated with colleagues in early help, Ihear and Community Safety Partnership to ensure a broad spectrum of courses available using local expertise and maximising local networking and knowledge of services in adults and children's services, reflecting LSCB priorities.

The training group has also been integral to rolling out a new package of E-learning funded by the Early Intervention Service (EIS). This has significantly expanded the range of learning opportunities available to the multi-agency workforce in Hounslow.

The LSCB programme of learning is well regarded and overall there has been good take up of face to face learning. E-learning take up is also fairly good, the Virtual College tell us Hounslow's completion rates are the best in the country. However E-learning represents a culture shift and there is some reluctance. The Training Sub Group quality assured the

package that EIS bought and user feedback is very positive. EIS, TSG and LSCB members will need to continue to promote E-learning to justify the expenditure generously committed by EIS.

Training Events Delivery

The LSCB annual course programme reflected these particular board priorities:-

Early Help Assessment.	Domestic violence work with women.
Core groups and child protection plans	Parental mental ill health
Distinguishing non accidental injury	Forced marriage and 'honour' violence
MARAC. Domestic Violence	FGM
'PREVENT'. Preventing radicalisation	Parental substance misuse
Neglect. Infants children young people	Familial Child Sexual Abuse

Additional courses maintaining curriculum on safeguarding older children and adolescents:-

Suicide awareness and prevention	Sexually active children and young people
Understanding self-harm working with young people	Child Sexual Exploitation
Abuse and violence in young people's intimate relationships	Gang involvement. Safeguarding children and young people
Substance misuse. Safeguarding young people	

New Domestic Violence Course Developed

In response to LSCB being challenged by domestic violence services and community safety partnership (CSP); TSG and CSP collaborated to develop a film and a new course that represents the voice of service users; women who have sought help in Hounslow. The women's stories expose some institutional practices, explored on the course, to enable and encourage workers to critically reflect on attitudes to mothers seeking help or involved in child protection services. The course is grounded in professional codes of conduct and the council customer charter and seeks to promote sophisticated understanding of domestic

abuse and empathic responses to women seeking help. By supporting mothers; to promote safety for children.

Total number of people attending courses: 809

(See tables later for individual numbers attending each course and agency representation)

Tackling Trauma Seminar (25th November event attended by 73 people)

This was well received and people were asking for more. The day introduced people to understanding the impact of trauma on the brain and the importance of being able to manage your own feelings and to help children and young people to manage theirs. Methodology based on treatment for PTSD in the armed services.

Harmful Cultural Practices Seminar (12th November attended by 148 people)

This was a challenging day arranged with a central Met Police team. Delegate feedback was that despite being a somewhat gruelling day it was important to raise and consider some potentially very harmful cultural practices of which many people have limited knowledge.

Virtual College Launched (Modules completed by 1227 people)

Early Intervention Service funded e learning and via the LSCB this was launched and made available to other partner agencies (with exception of health). Feedback is positive with people finding it a useful resource to allow them to read relevant material allowing a convenient and flexible compliment to face to face learning.

Child Sexual Exploitation eLearning

Reflecting the LSCB CSE priority. The Children and Adults Services director set a requirement for managers across children's services to ensure staff complete CSE e-learning to ensure broad awareness and appreciation across the children's services.

There are approx.390 staff in total. 240 have completed this e-learning

Third Sector

LSCB business manager and training manager arranged an event with third sector organisations to firm links between the sector and in key service areas including family information service, early intervention service, MASH, Community safety, Victoria Climbie Foundation and to promote training available. To date 16 have accessed face to face learning.

Improving evaluation of face to face courses. Progress made to date.

New Evaluation Form Devised and Trialled.

TSG revised our evaluation forms to gather a more quantitative picture of delegate feedback and ratings, as well as delegate commentary about the anticipated impact of learning on their day to day practice and capacity to safeguard and promote the welfare of children and young people. The revised form has been trialled and we are currently devising our analysis and post course evaluation is currently being developed with assistance from management information team.

Interview Based Evaluation of CSE Training.

TSG took advantage of an HR Masters student placement to explore the effectiveness of our CSE course. This was small scale as it was limited to interviews with only 8 participants over 3 days, (underlining the labour intensive nature of such ventures). Some changes were made course delivery as a result reinforcing the expectation to put learning into practice. Early signs are that effectiveness is improved, namely that delegates appear more likely to make changes to practice. Sample feedback from child sexual exploitation course responding to the question 'How will your everyday work change as a result of your learning today':-

- *'Using the Barnardo's tools with young people'*
- *''Use wheel of power tool with young people'*
- *'I feel more equipped to manage some difficult conversations'*
- *'Be more confident and proactive in approaching the subject with young people'*

Annual Conference.

LSCB Annual conference was planned and organised for May 2015 to promote a board priority to explore and promote more effective working between children's and adults services.

Work ongoing into 2015/16

Self-harm Scoping

The self-harm training group has continued offering self-harm workshops for a second year and in addition offering suicide awareness workshops. During workshops and at the local adolescent mental health forum concerns emerged about service availability, referral pathways and service criteria. The LSCB chair chaired a scoping meeting with partners. Various issues were raised that will be taken forward as an LSCB priority in 2015/16. Self harm and suicide awareness workshops project is ongoing.

Ongoing CSE focus driven by LSCB and children's services. CSE briefings to be undertaken by Vulnerabilities co-ordinator and LSCB training manager June-September with key specialist children's services EIS and youth service.

Planning annual courses programme and annual conference.

Priorities for 2015/16

- Courses programme and conference for next academic year to focus on child sexual abuse in all its forms. This decision was agreed by TSG in December 2014. The rationale for this is the declining number of cases of CSA coming to notice in the past two decades nationally, and the consequent lack of experience within the workforce as a whole. This has recently been reinforced by NSPCC research *(Martin. Social workers' knowledge and confidence when working with cases of child sexual abuse. 2014).*
- Maintain current focus on safeguarding of older children and teens, and all courses related to CSE.
- Develop/relaunch quality of care assessment.

Issues re functioning of TSG

TSG will be chaired by the business manager when the current chair leaves his post. We also need clarification about membership from Housing.

Tables

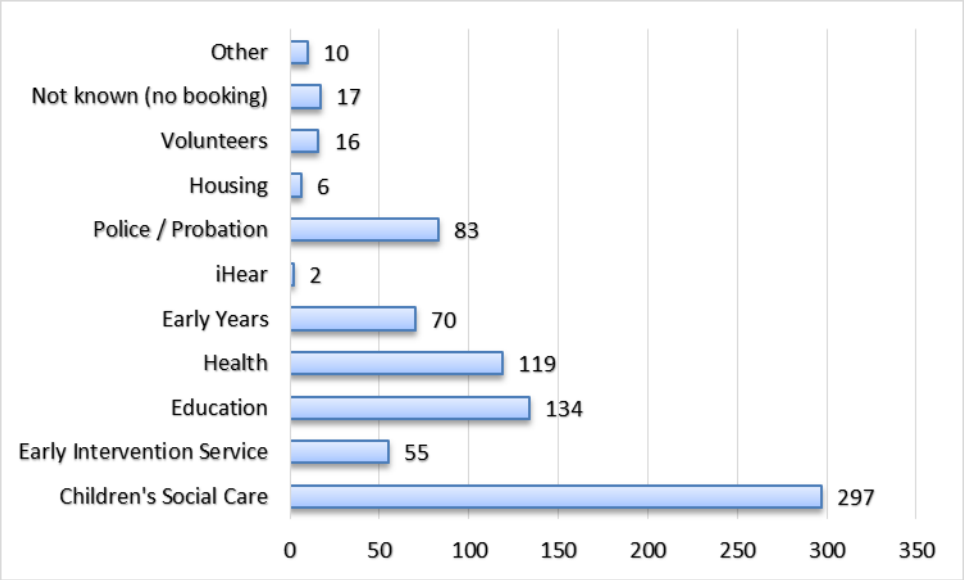
Numbers attending LSCB courses.

Sexual exploitation. Safeguarding young people	**110**
Foundation in safeguarding children	**126**
Foundation in safeguarding children with a disability	**23**
Core groups & child protection plans	**37**
Working with sexually active children & young people	**36**
Early Help Assessment	**94**
Recognising & responding to child sexual abuse	**12**
Domestic Violence. Children & YP & violence to parents	**32**
Multi agency risk assessment conference MARAC	**39**
Distinguishing accidental & non accidental injury	**28**
Neglectful parenting	**46**
Neglect of older children & young people. A reflective practice day.	**26**

Understanding deliberate self-injury & working with YP	**40**
Substance misuse. Safeguarding young people	**28**
Use and abuse of technology	**26**
Gang involvement	**46**
Violence against women and girls (VAWG)	**18**
YP mental health. Suicide awareness & prevention	**24**
Neglectful parenting	**18**

Total	**809**

Agencies Attending LSCB Courses



Virtual College

Modules and number completed. Total 1227.

Course	Completed
An Introduction to FGM, Forced Marriage, Spirit Possession and Honour Based Violence	67
An Introduction to Safeguarding Children	234
Awareness of Child Abuse and Neglect - Core	253

Awareness of Child Abuse and Neglect - Foundation	169
Awareness of Child Abuse and Neglect - Young People Version	11
Awareness of Child Abuse and Neglect Core Level - Police Version	7
Awareness of Domestic Violence and Abuse including the Impact on Children, Young People and Adults at Risk	29
Child Accident Prevention	16
Children's and Young People's Development in Health and Social Care Settings	13
Hidden Harm	22
Protecting Children from Child Sexual Exploitation	49
Parental Mental Health	13
Risk Taking Behaviour	9
Safeguarding and Leadership	25
Safeguarding Children from Abuse by Sexual Exploitation	263
Safer Recruitment	39
Think Safe, Be Safe, Stay Safe	1
Wellbeing in Sexual Health	7

Single Agency Safeguarding Training Reports Provided by Health Partners.

Safeguarding training requirements and eligibility criteria for health professionals are set out in "Safeguarding Children and Young People: Roles and Competences for Health Care Staff", Intercollegiate Document, March 2014 which states:-

'all staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. This responsibility also applies to staff working primarily with adults who have dependent children that may be at risk because of their parent/carers health or behaviour.

To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing'.

West Middlesex University Hospital Report.

The Intercollegiate Guidance 2014 resulted in a radical shift in eligibility for training with significantly more front line staff requiring training at levels 2 and 3 (see tables below). This has proved a significant challenge for the Safeguarding Team and the organisation due to an increase in numbers of staff requiring training and conflicting training requirements of adult nursing and medical staff in relation to CQUINs and other mandatory requirements. There were also a number of staff this year that required the three yearly refresher training.

Monthly each clinical division is issued with a spreadsheet with the names of staff requiring each level of training. In addition to the 'face to face' teaching sessions provided by the named professionals, staff have access to the Local Safeguarding Children Board multi agency training days, e-learning packages, conferences and modules via universities. Medical staff can access e-learning packages using GMC numbers and newly appointed doctors are encouraged to complete the programme before commencing employment at WMUH.

In 2014/15 92% Level 1 compliance was achieved for all staff. Compliance at level 2 has been a significant challenge and 80% was not achieved throughout the year. (March = 63%). 80% Compliance at level 3 (front-line staff) was met during the year, however at present there has been a slight dip in figures due to new Doctors starting in February.

The tables below demonstrate training compliance for all 3 levels at the time of this report.

Eligibility for Level 1

All staff. This is delivered by 'face to face' teaching sessions or via an e learning package.

Current Position: April 1st 2015

Total staff	1900
Total trained	1744
Percentage Compliance	92%

Eligibility for Level 2

Staff who have regular contact with children, young people and/or parents/carers including all health clinical staff. This is delivered by 'face to face' teaching sessions or via an e learning package

Current Position: April 1st 2015

Total staff eligible	1274
Total staff trained	805
Percentage	63%

The biggest challenge with level 2 is the release of the adult nursing workforce, particularly A&E. These staff should be encouraged to complete the e learning module to improve this position for 2015/16.

Eligibility for Level 3

For staff who predominantly work with children, young people and/or their parents/carers. This is delivered mainly by 'face to face' teaching sessions. However there is also an e learning package that has been developed and used within the Trust.

Current Position: April 1st 2015

Total staff eligible	392
Total staff trained	304
Percentage	76%

The Safeguarding team are 100% at level 4

The safeguarding team will continue to support the divisions in 2015/16 to achieve the 90% compliance required by CQC.

HRCH Report for Safeguarding Children and Young people Training.

The emphasis within the 2014 intercollegiate document continues to be upon the importance of maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies, critical incident reviews and analysis, and serious case reviews. The framework will be reviewed again in 2017

There continues to be an established process in place to assign an appropriate level of safeguarding (children) training at appointment. Safeguarding training is delivered according to the needs of the role and responsibility of the individual staff member within HRCH.

- Level I Safeguarding Children Training is provided in the induction programme and now incorporates adults at risk training and requires 3 yearly updates.
- Level 2 is provided within the organisation and is also required to be updated on a 3 yearly basis.
- The Level 3 safeguarding training is delivered by the Local Safeguarding Children's Board (LSCB) and some single agency 'in house' training has been delivered to ensure uptake and maintenance of skill set and requires a 3 yearly 1-2 day update and a ½ day annual update to maintain competency.

The WIRED report has become an established method of recording and monitoring safeguarding training compliance within HRCH. All staff members can take a personal responsibility to monitor their own compliance with statutory and mandatory training. Service managers and Directors have identified staff who have been consistently non-compliant with their required training and encourage staff to complete their training. There have made recent changes to WIRED to reflect the Trusts alignment to the Core Skills Training Framework (CSTF).

The safeguarding team have continued to prioritised the delivery of training; this commitment has ensured there has been continued high levels of staff receiving training.

Current Position: April 1st 2015

Eligibility for Level 1

All staff including non-clinical managers and staff working in health care settings.

Target for level 1	95%
Total staff trained	94.71%

Eligibility for Level 2

Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers.

Target for level 2	95%
Total staff trained	83.58%

Eligibility for Level 3

Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns

Target for level 3	85%
Total staff trained	78.43%

In order to maintain overall organisational compliance with safeguarding training targets, this work will remain a high priority for the Named Nurse and Safeguarding team.

Progress towards achieving the targets for all levels of training have been reported to the Director of Quality and Clinical Excellence on a monthly basis and will be continuously monitored and scrutinised by the HRCH Safeguarding Committee, Integrated Governance Committee (IGC), LSCB, and HRCH Trust Board.

West London Mental Health Trust Report

All staff receive safeguarding children Level 1, Level 2/3 training at induction.

All staff must attend refresher training which is mandatory every 3 years.

Level 1 Refresher Training

For all non-clinical staff who are not working in services where children and young people are seen.

Enables staff to recognise potential signs of child mal-treatment and neglect including the categories of abuse and understand the impact a parent or a carer's mental health may have on a child's daily lived experience. Staff will know who to contact and what to do if they are worried.

Level 2 Refresher Training

Is for all clinical staff up to AfC Band 5 (AfC - Agenda for Change is the NHS role banding); and non-clinical staff in services where children and young people are seen which includes CAMHS and peri-natal services. This category also includes all volunteers in the Trust.

Enables staff to recognise early signs of child maltreatment and neglect and increase awareness of the possible impact of poor parental mental health on the care of children (Think Family). Creates a greater awareness of professional responsibilities in the clinical

setting to safeguard and protect children of adult service users / those who have caring responsibilities and understand these responsibilities within the professional and legal frameworks. Staff will know who to contact and what to do if they are worried.

This training includes a focus on the effects of neglect, domestic abuse and violence, cultural practices, sexual exploitation and FGM.

Level 3 Refresher Training

Training delivered in-house as part of the Trust training portfolio for all clinical staff (AfC) Band 6 and above(including Psychiatrists) in adult services, and staff identified as local leads for safeguarding children, plus any clinicians who have identified this as a CPD need through their appraisal. This may include clinicians in band 5 who are at the frontline of service with responsibility for caseloads and casework and require a greater level of knowledge and expertise in safeguarding children.

This training enhances clinical and professional knowledge of what constitutes child maltreatment and the early identification of concerns for children; the gathering and sharing of information and where appropriate analysis of risk; contribution to inter-agency assessments and communication with other professionals and statutory agencies who safeguard and protect children.

Enables staff to competently review their own (and/or team) safeguarding/child protection practice and learn from national and local serious case reviews/case management reviews / significant case reviews. Includes an overview of Child Sexual Exploitation, Female Genital Mutilation, Forced Marriage, Radicalisation, Child Trafficking and Domestic Violence.

Level 3 Specialist Training

All staff who work directly with children and young people which are all clinical staff working in CAMHS and in Peri-natal mental health services.

The Level 3 specialist training consists of one day internal Trust Level 3 training plus one day external training which should be multi-agency and delivered by the LSCB or an external organisation / Conference.

Whole Trust Figures

(Hounslow numbers cannot be extracted).

Total number of staff trained approx. 3000 of which:

Level 1 – approx. 911

Level 2 - approx. 153

Level 3 - approx. 400

Level 3 specialist – approx. 150 (CAMHS)

Level 4 and above - 3 (Named Doctor, Nurse Etc...)

NB Staff numbers as of June 2015 – 3500 staff approx.

Training for GPs about domestic violence.

Public Health provided community safety funding to deliver DV training to GPs and other health care professionals. The Community Safety Team commissioned 'Ascent' to deliver the training. The CCG Chair supported this by writing to all GPs in Hounslow encouraging them to take up this free training to take place in GP practices as it is often difficult for GPs to be released to attend training.

The aim was to raise awareness amongst GPs about the incidence of domestic violence in Hounslow, the action that GPs may consider taking if they are concerned about a woman or man subjected to domestic abuse or concerned about children in a family, and support services that are available to adults and their affected children.

Out of 53 GP practices 39 had the training, 7 other health care providers also had the training. In total 238 staff in the practices attended.

GPs	Target	Achieved
Brentford	10	10
Chiswick	8	7
Feltham	13	10
Great West Road	11	5
Heart of Hounslow	11	7
TOTAL	53	39

Other Health Care Providers	Target	Achieved
Health Visitors/ School Nurses	1	3
Urgent Care Centres	2	2
Other - locum GPs	0	2
TOTAL	3	7

Feedback re quality of training from those who completed feedback forms.

Fair	13
Good	88
Excellent	63
Total	164

Education Network Report 2014/15

Work competed by the sub-committee completed in 2014/15

- **Elective Home Education -** Capacity increased though additional funding from Schools Forum for EHE enabled more children to be contacted who are being home educated.

- **Suicide prevention and self-harm** – Training material produced to support organisations on techniques and methods to discuss this issue with children and young people. The current materials cover suicide prevention and self-harm. A coordinating group rolled out this work which has schools input from a senior level.

- **Keeping Children Safe in Education: New guidance from the DfE -** Summary of the new Guidance. Highlighting any key changes in responsibility to all HTs and Chairs of Governors

- **On line safeguarding training** – Promotion and use of the on-line Safeguarding training materials**.** The feedback has been very positive and regular reminders are sent out about the online materials to schools.

- **Child Sexual Exploitation -** Headteacher Breakfast Briefing held on the 18th March 2015. Very well attended and 2 representatives, one from primary and one from secondary identified to sit on the new CSE subgroup of the LSCB.

- **Serious case Reviews -** Raised awareness with Education Providers on learning from SCRs from across the country.

- **Oversight and monitoring of any Safeguarding issues from Ofsted inspection of Education and Early years providers** – The network assessed and reported any safeguarding issues emerging from Ofsted inspections and reported these to the LSCB throughout the year.

Work that is ongoing into 2015/16

- Continuing to work with schools and other education providers on CSE.

- Rolling out more widely the training and support to schools on Suicide prevention and self-harm.

- Promote and monitor the uptake of training including the on line safeguarding training materials available to schools and education providers.

- Monitor and where appropriate address any safeguarding issues emerging from Ofsted inspections of schools, early years and childcare settings and other education providers.

Priorities for 2015/16

- Brief and support schools and other Education providers on working with children and young people at risk of Radicalisation.
- Strengthen the safeguarding lead network across schools and other education providers, updating them on any emerging issues in Hounslow.
- Review and update the protocol for Safeguarding, Education and Social Care Protocol
- Establish an LSCB resource and information point for schools on the Council's Knowledge Hub.
- Analyse and share any learning from Ofsted safeguarding notifications to the LA.
-

Issues re the functioning of the sub committee

- The network is functioning more effectively than ever before. However, the changing nature of schools and the increased independence and autonomy of schools, means that it is virtually impossible to ensure that all schools are 'represented' by the network but it does retain a key function as a conduit and communicator on safeguarding matters between the LSCB and providers of Education in Hounslow

Health Network Report 2014/15

Overview of key areas discussed

- Training
- Supervision
- Quarterly safeguarding reporting
- FGM
- LAC
- Standardisation training evaluation form across agencies
- MASH
- CAMHS referral thresholds
- Virtual college e-learning module on CSE
- CQC inspection prep
- MARAC referrals and DV
- Update on learning from Savile report
- Audits updates

Work completed by the sub-committee in 2014/15

- The Hounslow Community Safety Team is providing MARAC training to GP practices across the borough with the intention of increasing referrals from health
- The group was involved in the setting up of postnatal depression groups in Brentford. Hounslow IAPT is also involved and will run a group in Brentford Health Centre started in June 2014.
- A couple of focus groups were set up to ascertain the "voice of the child". The response was zero and the DN accompanied the outreach officer to the college opportunistically with the results attached. During the discussion, it came to light that from the group they were concerned about 'gambling' and the tutor who reported that there appears to be a gap in service in regards to Bereavement Counselling for young people.

local college survey 2014.docx

- An FGM audit was completed in November/December 2014. This was an audit into the current practices around the identification and management of FGM across acute and primary care within the borough of Hounslow.
- All health services commissioned by the CCG have been asked to set up systems within their organisation to record FGM information and report back quarterly. A list of FGM services across London was given out to the group members to disseminate within their organisations.
- Scoping exercise on self-harm and suicide was completed on 4th February 2015.

Work that is ongoing into 2015/16

- To prepare for CQC inspection on safeguarding and LAC to ensure that health agencies have made robust preparations for the inspection and then to monitor the action plans and outcomes from CQC recommendations.
- To monitor the action plans form the SCR and also any case reviews and link into LSCB SCR sub-group.
- For any safeguarding audits that health agencies have undertaken that the learnings are shared across the health economy and any identified learning implemented to improve services and to link into LSCB ME sub-group.
- A review of MARAC and health economy's engagement with the process and information sharing from HRCH to the GP's in terms of MARAC.
- To monitor the merger of WMUH with Chelsea and Westminster in terms of the effect of the safeguarding arrangements to ensure they are safe, robust and maintained during the merger period and any future developments that could impact on the local health economies are identified and actioned.
- To monitor and evaluate the supervision processes across the health economy.
- To monitor, review and evaluate the safeguarding training across the health economy whilst maintaining links with the LSCB sub training group.
- To monitor health economy's current safeguarding arrangements in regards to processes, analysis of risk and management of Child Sexual Exploitation.
- To review mental health arrangements and their reporting arrangements to ensure that safeguarding focus is maintained.

- Critically evaluate early help process across the health economy.
- To monitor health economy's current safeguarding arrangements in regards to processes, analysis of risk and management of FGM.

Priorities for 2015/16

- For health agencies to make robust preparations for CQC inspection ensuring that they are compliant with Section 11 requirements and the CQC TOR's to safeguarding children and young people.
- To ensure that partnership arrangements across health services and other agencies are robust, maintained and safe during the transitional period of merger of WMUH.
- Terms of Reference for the group to be reviewed and updated and also to look at membership and functioning of the group.
- FGM, CSE and early help.
- For health network to be outcome focused to ensure improved outcome for children within the health economy.

Issues re the functioning of the sub-committee

- No major issues
- We have good representation from all provider organisations Attendance remains fair across agencies with the exception of London Ambulance Service (LAS) but this is improving.

The link made with Public Health remains strong and consistent

Annual Safeguarding Performance Report for 2014/15

1. **Contacts, Referrals and Assessments**
   - 1.1. Contacts
   - 1.2. Referrals
   - 1.3. Assessments
   - 1.4. Referrals going to initial assessment
   - 1.5. First and Subsequent assessments
   - 1.6. Analysis

2. **Child Protection Plans (CPP)**
   - 2.1. Children subject to a CPP
   - 2.2. Children subject to a CPP over 4 years
   - 2.3. Children subject to CPP by category
   - 2.4. Children for whom a CPP has started
   - 2.5. Children for whom a CPP has ended
   - 2.6. Children with a repeat CPP
   - 2.7. Children with a CPP lasting 2 years or more
   - 2.8. Analysis

3. Looked After Children (LAC)

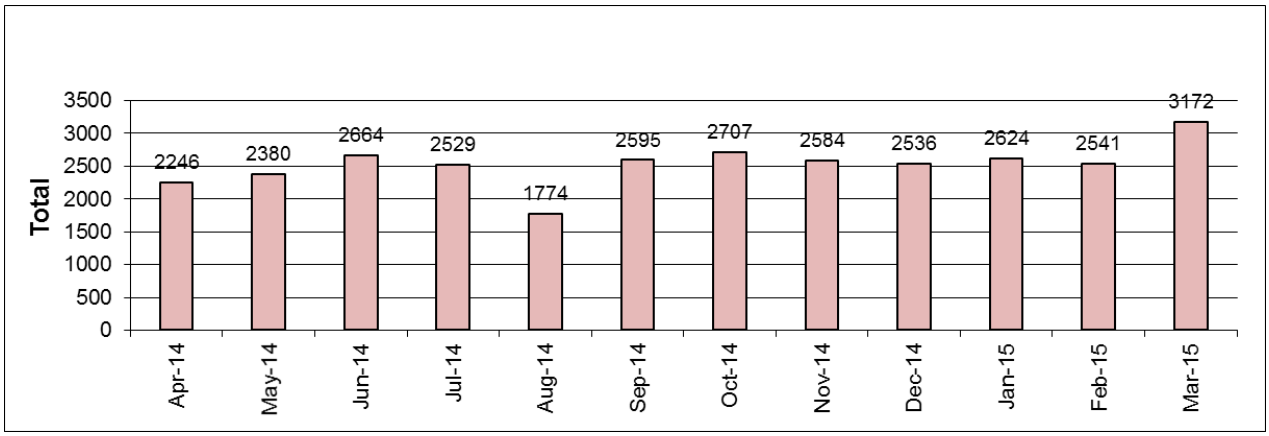
3.1. Total number of LAC
3.2. Total number of LAC over 4 years
3.3. LAC by age
3.4. LAC placed over 20 miles from their home address
3.5. Children becoming LAC by age (admissions)
3.6. Children becoming LAC by age (discharges)
3.7. Care orders by category
3.8. Analysis

4. Missing LAC

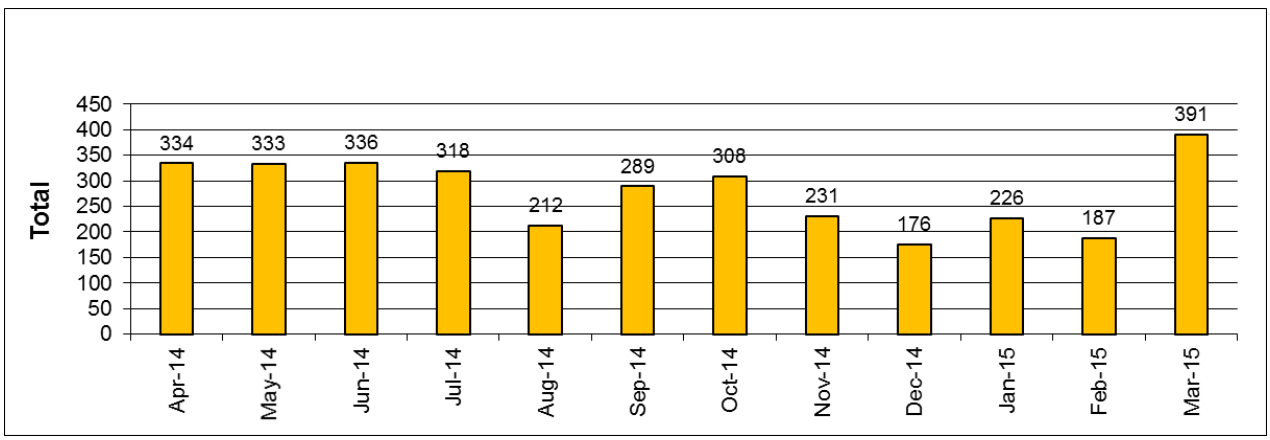
4.1. Missing LAC and episodes
4.2. Analysis

1. Contacts, Referrals and Assessments

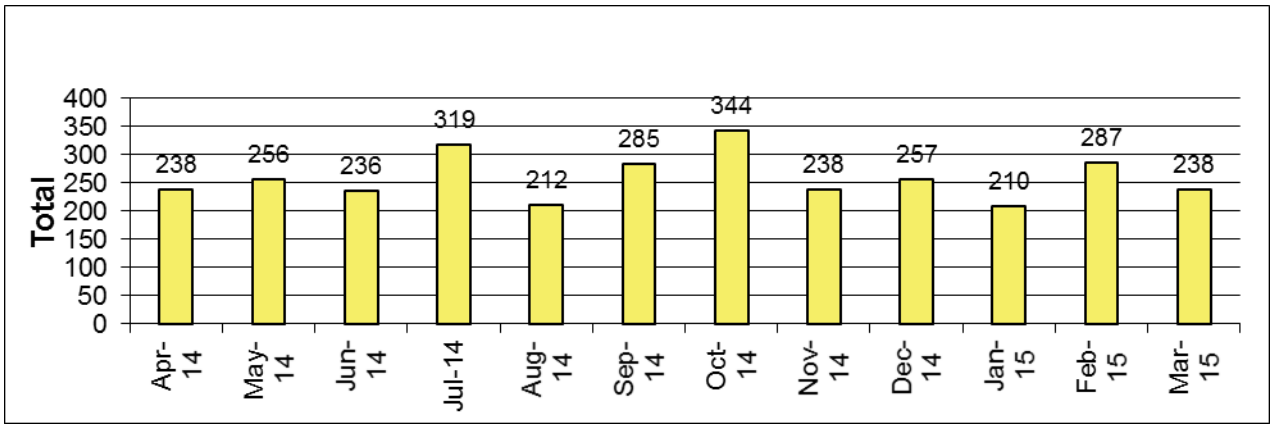
1.1. Contacts



1.2. Referrals



1.3. Assessments



1.4. Referrals going to initial assessment

Percentage of referrals to Children's Social Care going on to initial assessment	**Qtr 1**	**45.5%**	**Target:** **80%**
	Qtr 2	**59.3%**	
	Qtr 3	**71.2%**	
	Qtr 4	**Not applicable***	
	Year End Not Applicable*		

In December 2014, there was a change to continuous assessment that resulted in new data on referrals being incompatible with the data previously collected. Information based on the new arrangements will become available during 2015/16

1.5 First and Subsequent assessments

Percentage of first	**Qtr 1**	**82.6%**	**Target:**

and subsequent assessments for Children's Social Care carried out within 45 days	**Qtr 2**	**75.0%**	**85%**
	Qtr 3	**80.8%**	
	Qtr 4	**78.6%**	
	Year End 79.2%		

1.6 Analysis and service development

Other indicators that are monitored include:

- Number of contacts: 30,352 in the year, up from 23,601 in 2013/14
- Contacts actioned within 24 hours: 97.8%, up from 89.5%
- Number of referrals: 3,341, up from 2,648
- Percentage of repeat referrals within 12 months: 25.2%, up from 16.5%

In December 2013, Early Help Hounslow (EHH) took over Hounslow children's services' 'front door' and in doing so began to log those contacts which historically were only for their service and were therefore not previously recorded. This means that we cannot compare year-on-year figures until 2015/16.

When EHH took over the front door, there was an initial increase in the number of referrals to 1,003 in Q1 before the figure declined to 821 in Q2 and 710 in Q3. However, the number increased to 804 in Q4, suggesting that referrals may remain at a higher level now that new arrangements are in place. There has also been a year-on-year decrease in the percentage of referrals going on to assessment – the figure for Q3 was 71.2%, compared with 85.2% in Q3 of 2013/14. However, this represents continuing improvement since Q1 (45.5%) and Q2 (59.3%). Q4 and full-year figures are not available because of the introduction of continuous assessments in December 2014, which has affected the indicator.

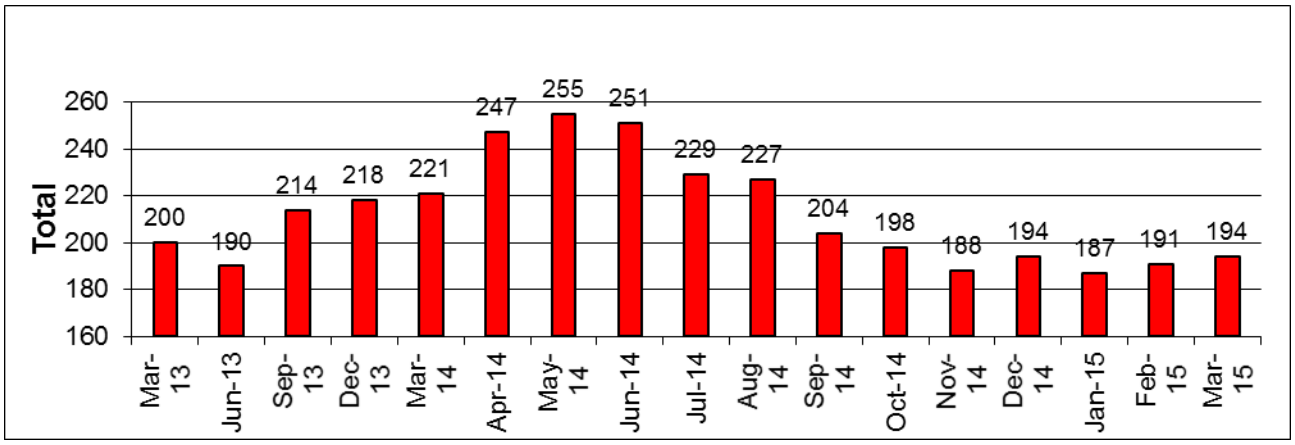
Early Intervention and Social Care continue to meet regularly and a joint programme of audits was undertaken in November/December 2014, with a focus on cases where referrals did not progress to assessments. The Early Help service was independently reviewed in March 2015 with a number of recommendations being made, and there is now an improvement plan in place that is addressing these.

Measures of timeliness in relation to continuous assessments will be important to performance analysis in 2015/16, and is being considered by the Management Information Team in consultation with senior managers.

The percentage of Section 47 investigations completed within 20 working days, at 93.3%, is an improvement on the 2013/14 figure of 91.5%. Within that figure, the majority of investigations took place well within timescale, with around 78% of Section 47s completed within 10 days and 90% within 15 days. It is those on the edges taking longer to complete that need to be monitored.

2. Child Protection Plans (CPP)

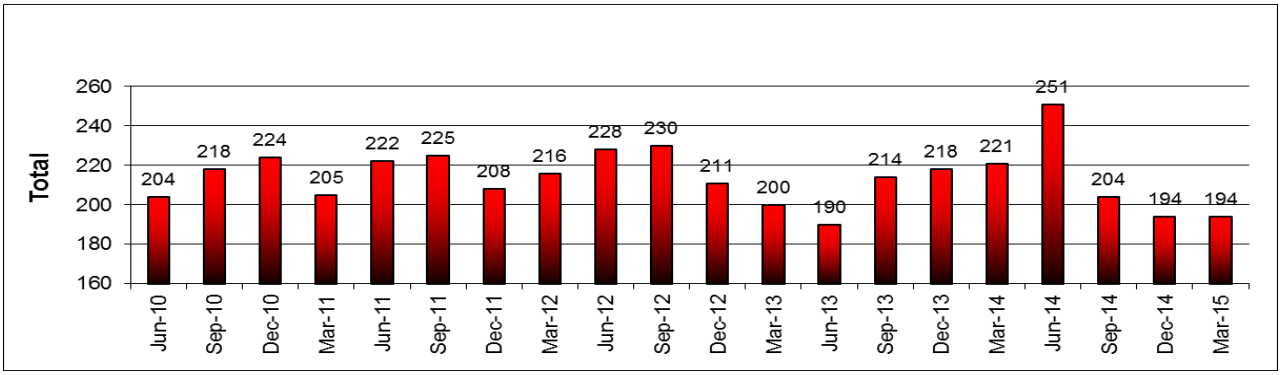
2.1. Children subject to a CPP



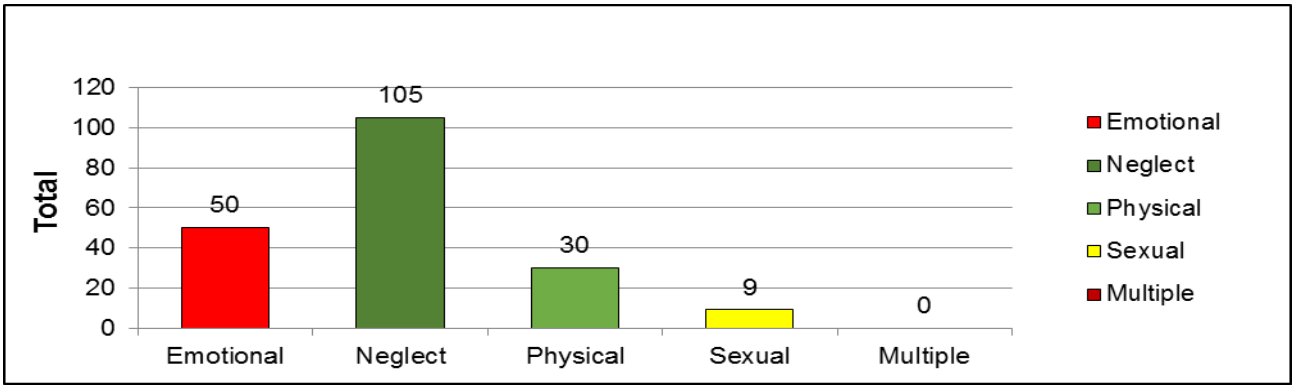
- The Hounslow CPP rate per 10,000 population is 32.3
- The West London average per 10,000 comparative figure is 36.7. This includes the five London Boroughs of Brent, Ealing, Hounslow, Hammersmith & Fulham and Hillingdon as at March 2014
- The outer London average per 10,000 population for 2013 is 35.1
- The current estimate used for under-18s in Hounslow is 60,100

The number of children currently subject to a CPP has decreased from the higher rate seen in spring 2014 and is currently maintaining at a lower rate, similar to that seen in summer 2013. The number has remained similar since October 2014, and remains low by comparison to most previous figures.

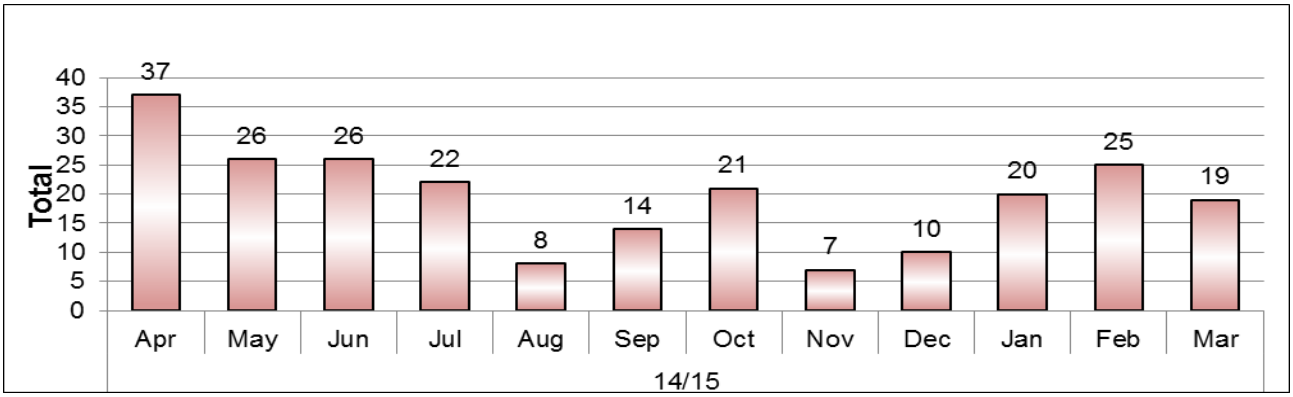
2.2. Children subject to a CPP over 4 years



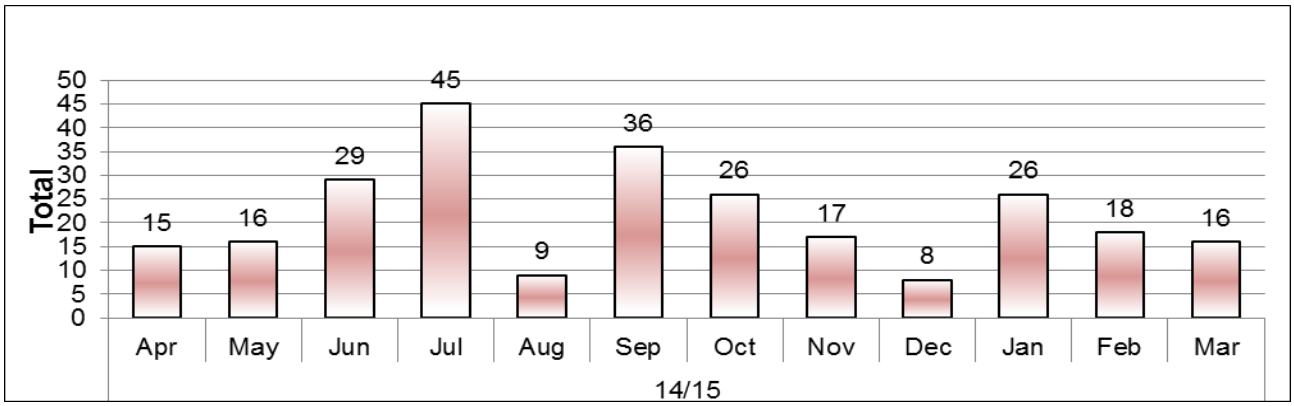
2.3. Children subject to CPP by category



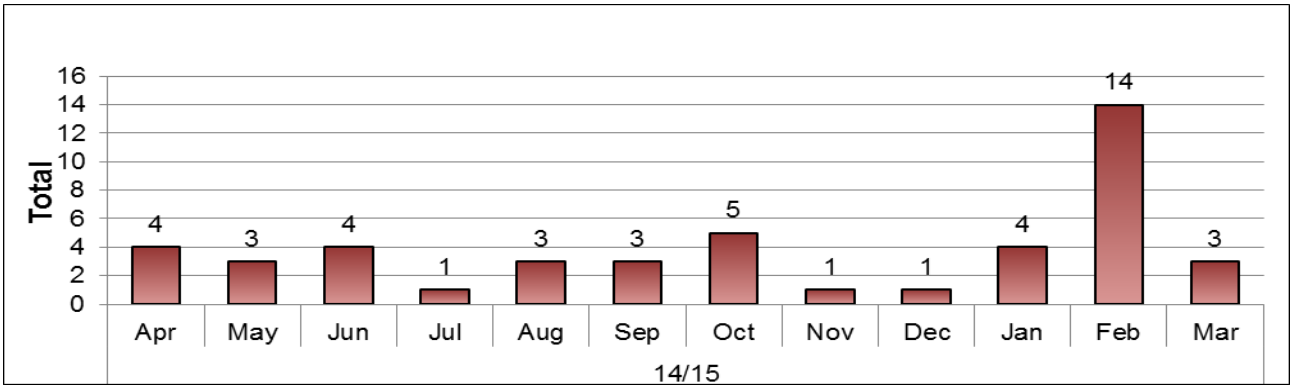
2.4. Children for whom a CPP has started



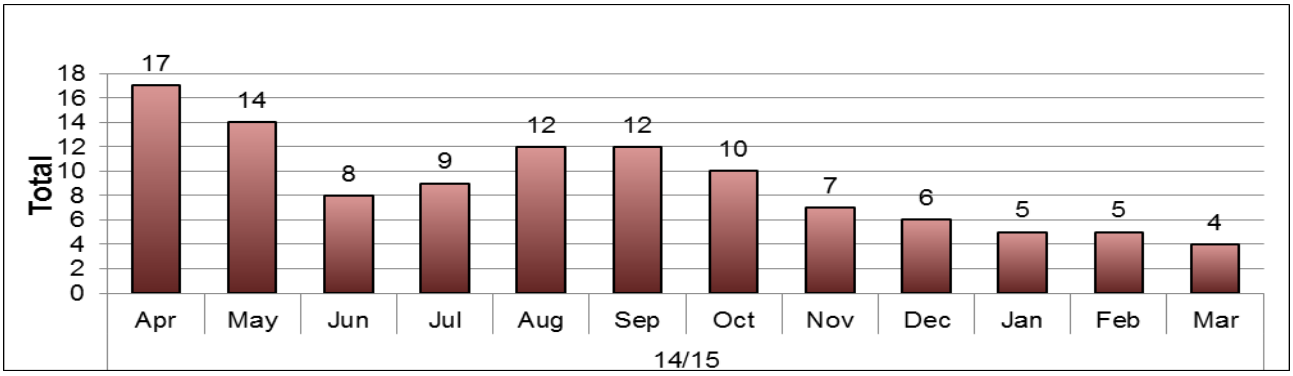
2.5. Children for whom a CPP has ended



2.6. Children with a repeat CPP



2.7. Children with a CPP lasting 2 years or more



2.8. Analysis

At the end of 2014/15:

- 194 children were subject to a CPP, down from 222 year-on-year, and substantially down from 251 in Q1 of 2014/15
- 235 children had become subject to a CPP in the year, down from 258 year-on-year
- 261 children had ceased to be subject to a CPP, up from 236 year-on-year

The following indicators are monitored through DLT performance reporting:

Percentage of child protection cases which were reviewed within required timescales	**Qtr 1**	**97.6%**	**Target: 98%**
	Qtr 2	**98.2%**	
	Qtr 3	**97.5%**	
	Qtr 4	**96.2%**	
	Year End 97.9%		

Ensure that children and young people at risk of abuse or neglect	**Qtr 1**	**91.1%**	**Target: 90% within 25 days of the**
	Qtr 2	**93.9%**	

have a timely and comprehensive multi agency plan to protect them	**Qtr 3**	**88.7%**	**start of the investigation**
	Qtr 4	**93.2%**	
	Year End 91.7%		

No more than 7% of children require a CPP for more than two years	**Qtr 1**	**3.2%**	**Target: 7%**
	Qtr 2	**5.9%**	
	Qtr 3	**3.1%**	
Reduce the	**Qtr 1**	**12.4%**	**Target:**
	Qtr 4	**2.1%**	
	Year End 4.2%		

percentage of children subject to a CPP for the second time	**Qtr 2**	**15.9%**	**11%**
	Qtr 3	**16.2%**	
	Qtr 4	**32.8%**	
	Year End 19.1%		

Other indicators that are monitored include:

- Number of initial child protection case conferences (ICPCCs) held: 265 in the year, down from 272 in 2013/14

It is noted that numbers of CPPs are significantly down from Q1; however, Q1 was exceptionally high in terms of the number of ICPCCs held and children becoming subject to a CPP. In 2014/15, there were fewer CPPs starting but more ending than in 2013/14, supporting figures suggesting that the total number of plans decreased during the year.

Timeliness of initial child protection conferences has more than met its target of 90% of the year, with only 22 of 265 initial conferences held outside the timescale compared to 42 of 272 in 2013/14. For 2015/16, we will be setting a more challenging deadline of 20 working days for the initial conference rather than 25 as at present, with the target remaining at 90%. This will force us to focus on timeliness for all children instead of the decreasing number of conferences that fall outside of the existing target.

The number of children subject to CPPs for more than 2 years has continued to remain well below the target of 7%. With tighter monitoring from the PLO board on timeliness and the continued development of the third Safeguarding & Support Team, this figure is likely to remain good.

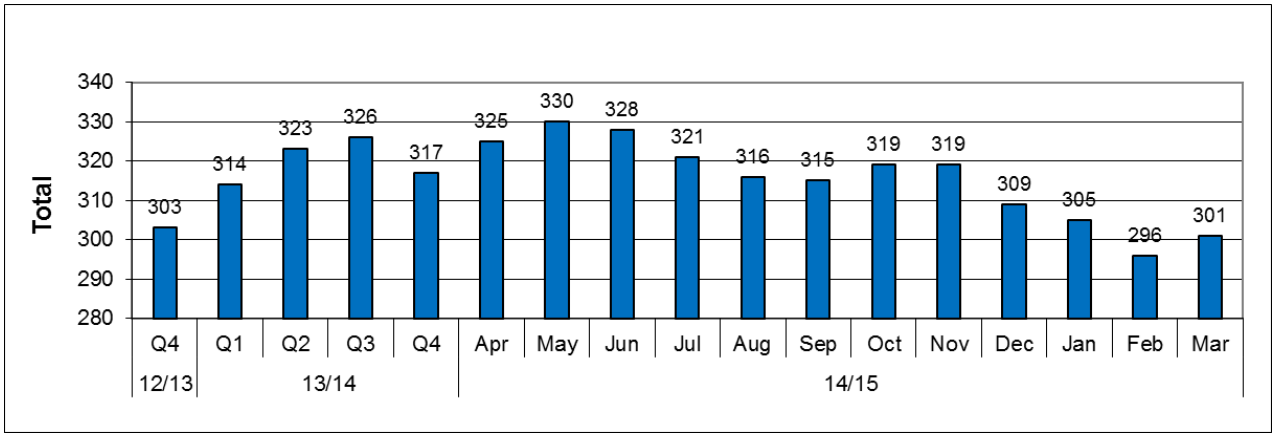
The proportion of repeat plans has increased every quarter in 2014/15, comprising 45 of 235 new plans at year end. Senior managers have conducted an analysis of children experiencing repeat plans, finding that most repeat plans take place years after the original plan with very few within 12 months.

The service has introduced a new audit tool targeted at cases where there is potential for drift in meeting outcomes, and one trigger for the audit to be undertaken is a repeated CPP. When completed, a review of these drift audits will assist in better understanding any trends or themes around repeat CPPs.

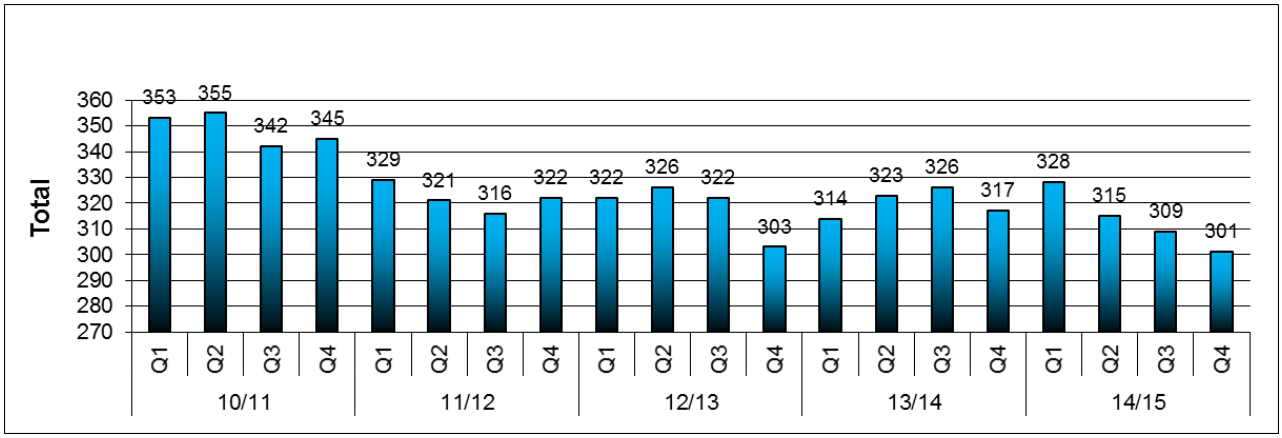
Early Intervention makes services available to children who are subject to a CP plan. These allows for the earlier involvement of these services before the CPP ends, followed by a smoother 'step down' process from Social Care to Early Intervention with the aim that this will further reduce the number of repeat CPPs.

3. Looked After Children (LAC)

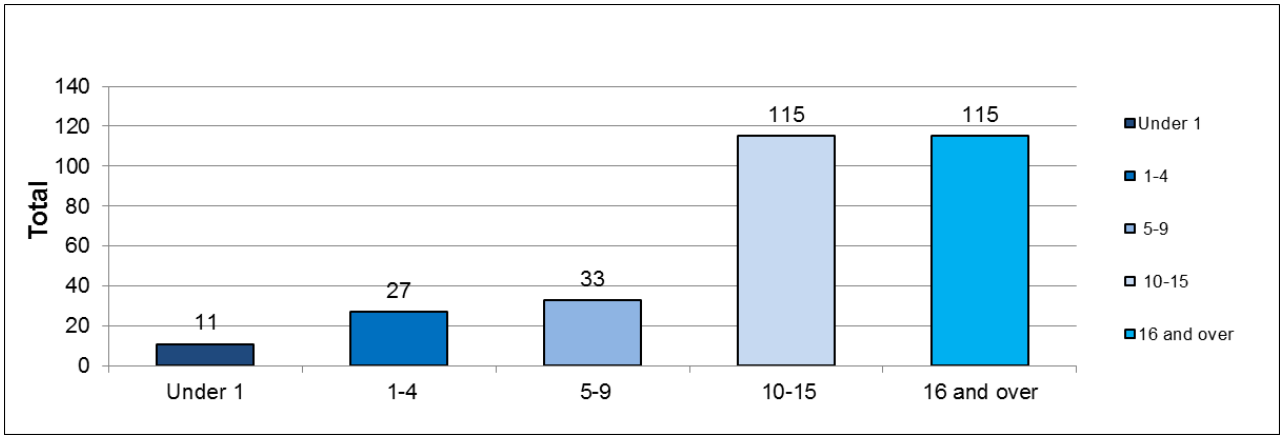
3.1. Total number of LAC



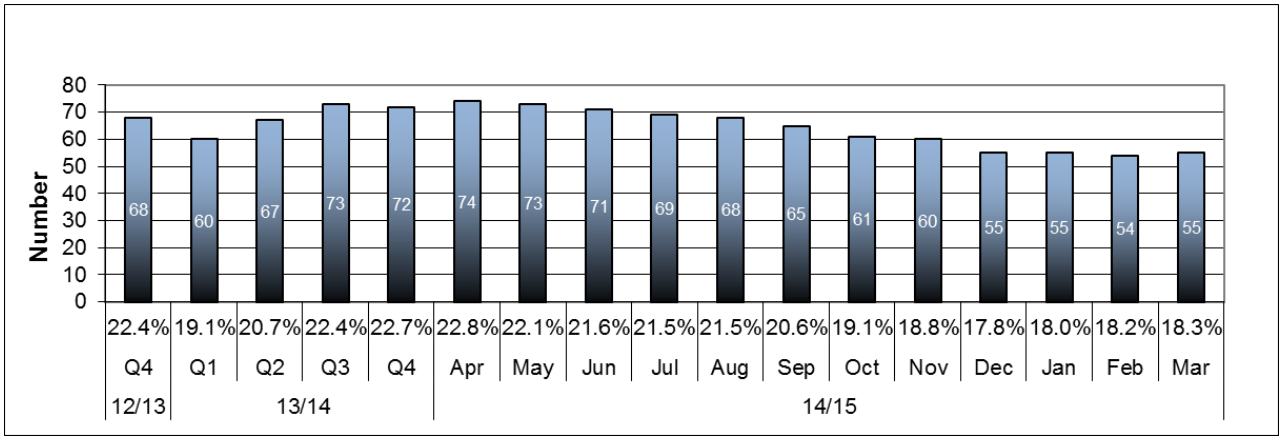
3.2. Total number of LAC over 4 years



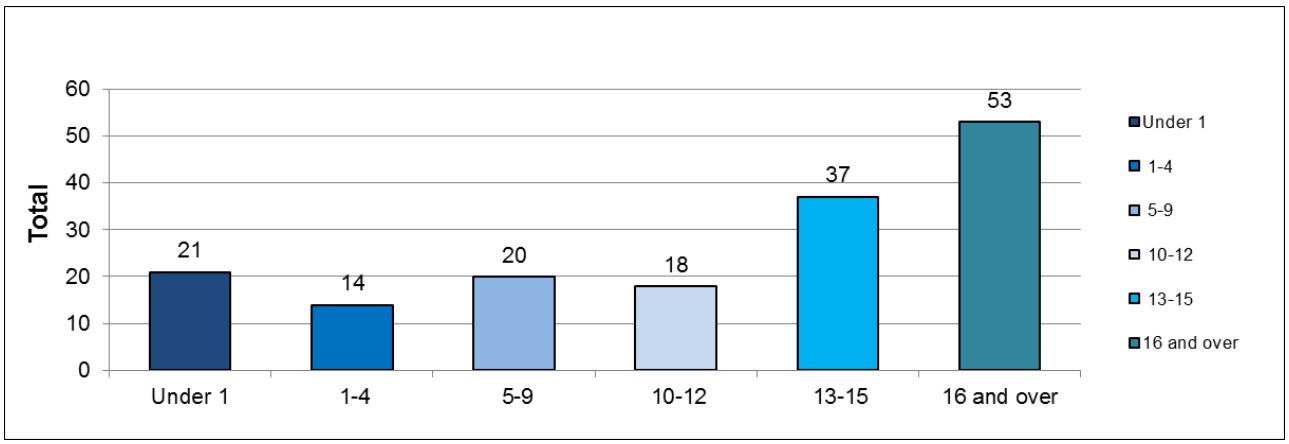
3.3. LAC by age



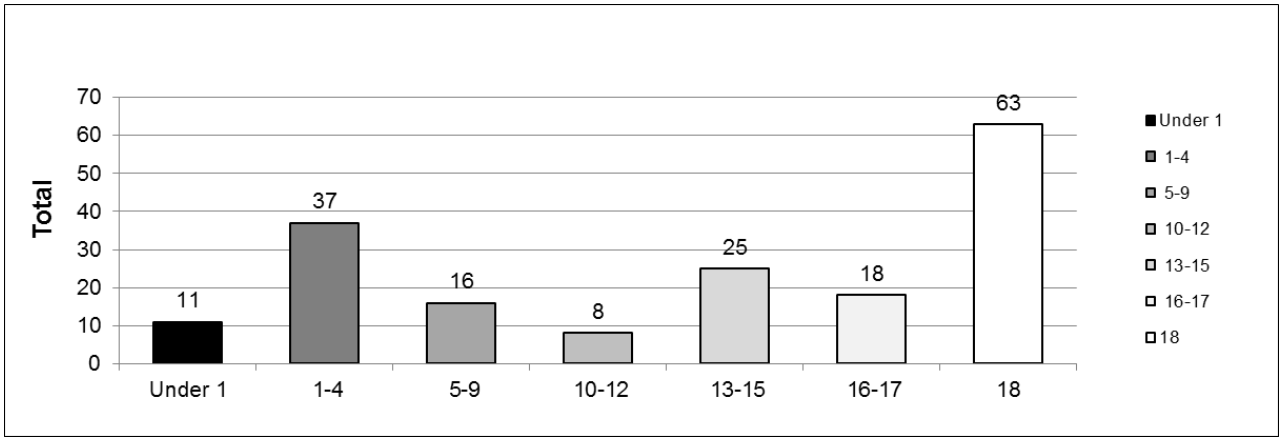
3.4 LAC placed over 20 miles from their home address



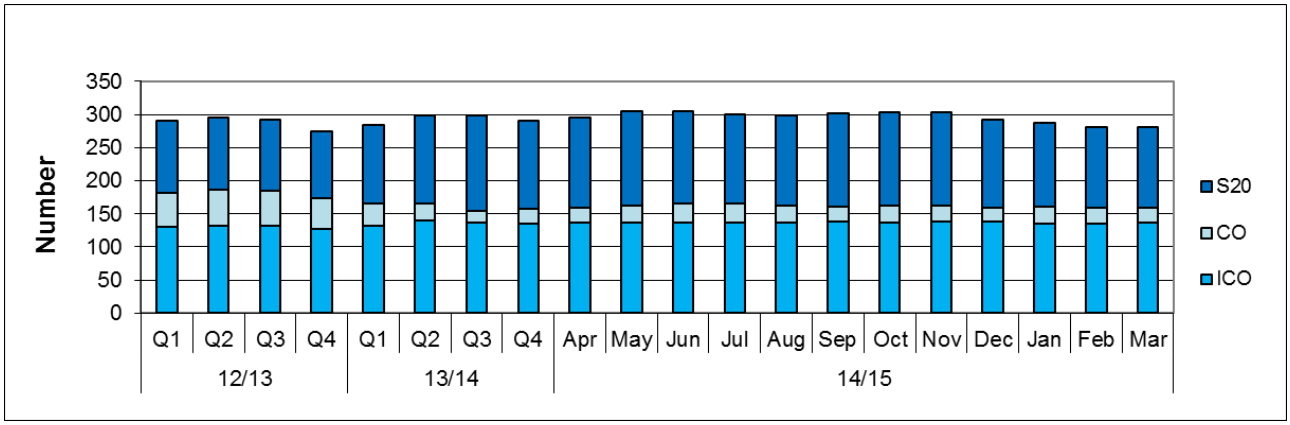
3.5 Children becoming LAC by age (admissions)



3.6 Children becoming LAC by age (discharges)



3.7 Care Orders by category



3.8 Analysis

At the end of 2014/15:

- 40% of LAC were accommodated under Section 20, down from 42% at the end of 2013/14
- 45% of LAC were subject to a full care order, up from 43%
- 8% of LAC were subject to an interim care order, up from 7%
- 4% of LAC were subject to a placement order, down from 8%

These figures tend to vary by a few percentage points each quarter and represent the position relating to the entire LAC cohort at the end of the month in question (March 2014 and March 2015 for the figures above).

The proportion of children accommodated under Section 20, which was stable at around 33% in 2012/13, saw a marked increase during 2013/14 and has been relatively stable during 2014/15. In real terms this equates to an increase from 100-110 children to around 120, given the concurrent decline in the LAC population.

The Specialist Intensive Support Program (SISP) provides long-term therapeutic interventions to children at risk of becoming accommodated in care. It has been running since 2010, with provisional figures suggesting that of 236 children with whom the service has worked and who are still being tracked, only 31 (13%) have been accommodated. The remainder has not been admitted to care. This does not mean that the remaining 205 children would necessarily have entered care,

but the service works on the basis of referrals from other social care services where there is felt to be a high risk of this outcome.

The Family Adolescent Assertive Support Team (FAAST) is intended to prevent young people becoming accommodated under Section 20. Figures to date suggest that, as in the case of the SISP service, a large majority of the cohort worked do not subsequently enter care. However, the service is relatively new and further analysis is required. This work will be conducted with a view to whether the preventative impact of both SISP and FAAST can be evaluated consistently. Reduction in admissions to care forms part of Hounslow's placement demand management strategy.

The new Step Change[1] program, partly funded by the Department for Education Innovation Fund, is in development in Hounslow. When operational it will offer further evidence based approaches to prevent children and young people entering care.

[1] https://www.actionforchildren.org.uk/what-we-do/services-for-professionals/evidence-based-programmes/step-change/

4. Missing Children

4.1. Analysis

Table 1 lists the number of children reported missing in each calendar month and the total number of missing episodes reported for these children within each month. This demonstrates that many children had repeated missing episodes, even within a single month. The Table 1 summary shows that, for the whole of 2014/15, 52 children were reported missing at least once. This number is significantly lower than the sum of children missing in each month because most missing children during 2014/15 had missing episodes in more than one calendar month.

Calendar Month	LAC Missing from Care	
	Children reported missing	Missing episodes reported
April 2014	14	43
May 2014	15	61
June 2014	13	39
July 2014	18	45
August 2014	20	64
September 2014	19	64
October 2014	14	57
November 2014	23	57
December 2014	18	46
January 2015	7	11
February 2015	7	9
March 2015	21	44
Total number of missing episodes in 2014/15		**540**
Number of children reported missing one or more times in 2014/15	**52**	
Children still missing on 31/03/2015	**1**	

Table 1: Missing LAC and episodes by month, by year and LAC still missing at 31st March 2015

There are some further observations of missing LAC data:

- Average length of a missing episode was 2.7 days (they ranged from 0 to 169 days)
- August and September had the highest number of missing episodes: 64 each
- January and February had the lowest number of missing episodes: 11 and 9 respectively

For the 52 children referred to in Table 1, Table 2 shows the number of months in which they had at least one missing episode. 37% of missing LAC had a missing episode/s in just a single month, with the remainder having missing episodes in between two and ten months. This indicates a split

between LAC who had one or two isolated missing episodes, and those who experienced a much high number over many months - 71 episodes in the most extreme case.

Number of separate months in 2014/15 in which the child had at least one missing episode	**LAC Missing from Care**
	No. of Children
1	19
2	4
3	7
4	5
5	4
6	2
7	5
8	2
9	2
10	2
Total	**52**

Table 2: Number of separate months in 2014/15 that missing LAC experienced at least one missing episode

LAC missing from care were the subject of significant scrutiny at a very senior level during 2014/15. As a result of this scrutiny, from December 2014 social workers were mandated to record missing child data on the social care database, Liquidlogic Protocol (known locally as LCS), using a defined method. In January 2015, previous missing episodes recorded by the Emergency Duty Team were added to this database. The recording in LCS is broken down by LAC status: looked after, not looked after and children from other local authorities. The challenges in accurately recording missing episodes have been addressed with social workers and their managers. Consistency in recording will allow better “real time” tracking of young people who place themselves at risk by being absent from their placement. This recording practice will become embedded during Q1 and Q2 of 2015/16.

Aided by these changes, the Children's Performance Team made significant progress in producing more accurate reporting in 2014/15, allowing concern to be focused on what the data is telling us, such as the risks faced by missing children and that some children have multiple missing episodes.

As in most local authorities, there is in Hounslow a cohort of LAC who regularly go missing. In most cases their whereabouts are known, but the intention is to have a "grab pack" in place for all LAC by June 2015 – a pack of information about a young person that will help in finding them and appraising the risks that they may face while missing.

A coordinator for exploitation and vulnerabilities was appointed during 2014/15 and is focusing on child sexual exploitation, including in relation to children who go missing.

Board Priorities for 2015/16

The Business Planning day of the Board established the Board's priorities for 2015/16 as:

- Child Sexual Exploitation
- Neglect
- Self-harm
- Female Genital Mutilation
- Forced Marriage
- The Board's overview of Early Help in Hounslow

Appendix 1

The Membership of the Board (March 2015)

Name	Designation	Role
Donald McPhail	LSCB Independent Chair	Chair of the LSCB
Alan Adams	Director of Children's and Adults Services, LB Hounslow	Member of the Board
Sarah Bennett	CDOP Coordinator	Member of the Board • Member of CDOP • Member of Case Sub-Committee
Kylee Brennan	Borough Manager, iHear	Member of the Board
DCI Mark Broom	DCI, Hounslow Borough Police, Metropolitan Police	Member of the Board • Member of Monitoring & Evaluation Sub-Committee • Member of Case Sub-Committee • Member of Missing and Vulnerable Sub-Committee
Nicky Brownjohn	Associate Director of Safeguarding, CWHHE CCG	Member of the Board • Chair of Cases Sub-Committee (September 2014-present)
Councillor Tom Bruce	Lead Member for Children, Young People and Families, LB Hounslow	Participant Observer of the Board
Permjit Chadha	Community Safety Manager, LB Hounslow	Member of the Board • Member of Training Sub-Committee
Imran Choudhury	Director of Public Health, LB Hounslow	Member of the Board
Stuart Crichton	Operations Manager, Ambulance Service	Member of the Board
Clarisser Cupid	Designated Nurse for Safeguarding Children, NHS England, Hounslow CCG	Member of the Board • Member of Monitoring & Evaluation Sub-Committee • Member of Feltham YOI

		Sub-Committee • Member of Missing and Vulnerable Sub-Committee • Member of Training Sub-Committee • Member of Health Network • Member of Case Review Sub-Committee
Steve Davis	Deputy Headteacher Representing Hounslow Secondary Schools	Member of the Board
Chris Domeney	Head of the Youth Offending Service, LB Hounslow	Member of the Board • Chair of Feltham YOI Sub-Committee • Member of Monitoring & Evaluation Sub-Committee • Member of Missing and Vulnerable Sub-Committee
Niamh Farren	Assistant Chief Officer, Hillingdon and Hounslow, Probation Service	Member of the Board
Siobhan Gregory	Director of Quality and Clinical Excellence, HRCH, NHS	Member of the Board
Mary Harpley	Chief Executive, LB Hounslow	Member of the Board
Paul Hewitt	Head of Safeguarding & Quality Assurance, LB Hounslow	Member of the Board • Chair of Monitoring & Evaluation Sub-Committee • Chair of Missing and Vulnerable Sub-Committee • Chair of Training Sub-Committee • Chair of Case Review Sub-Committee (August 2014– September 2014) • Member of Feltham YOI Sub-Committee • Member of Education Network

		• Member of CDOP • Member of Case Sub-Committee
DCI Coretta Hine	DCI, Child Abuse Investigation Team, Metropolitan Police	Member of the Board
Janet Johnson	LSCB Training & Development Manager	Training & Development Manager • Member of Training Sub-Committee
James Jolly	Assistant Chief Officer, Hounslow, Kingston and Richmond, Probation Service	Member of the Board
Shan Jones	Director of Quality Improvement, West Middlesex University Hospital	Member of the Board • Member of Case Review Sub-Committee
Debra Kane	Headteacher Representing Hounslow Primary Schools	Member of the Board
Monica King	Named Nurse Safeguarding Children, West London Mental Health Trust	Member of the Board
Bhupinder Lakhanpaul	Lay Member	Member of the Board
Michael Marks	Assistant Director, Education and Early Intervention Service, LB Hounslow	Member of the Board • Chair of Education Network • Member of Case Sub-Committee
Jacqui McShannon	Assistant Director of Children's Services, LB Hounslow	Member of the Board • Vice Chair of the Board • Member of Case Sub-Committee
Melissa Neilson-Rai	LSCB Business Manager	Business Manager • Member of Feltham YOI Sub-Committee • Member of Education Network • Member of CDOP • Member of Case Sub-Committee • Member of Monitoring & Evaluation Sub-Committee • Member of Missing and Vulnerable Sub-

		Committee • Member of Training Sub-Committee
Margaret O'Connor	Voluntary Sector Representative, LB Hounslow	Member of the Board
Johan Redelinghuys	Director of Safeguarding Children and Vulnerable Adults, West London Mental Health Trust	Member of the Board • Member of Case Review Sub-Committee
Dr Nirmala Sellathurai	Designated Doctor for Safeguarding Children, NHS England, Hounslow CCG	Member of the Board • Chair of Health Network • Member of Case Sub-Committee
Roger Shortt	Education In Partnership Facilitator, LB Hounslow	Member of the Board
Alison Stewart-Ross	Service Manager, NSPCC	Member of the Board
Judi Walsh	Senior Service Manager, CAFCASS	Member of the Board
Jonathan Webster	Director of Quality, Nursing & Patient Safety	Member of the Board
Glyn Williams	West Thames College Representative	Member of the Board
Caroline Wright	Head of Safeguarding at Feltham YOI	Member of the Board • Member of Feltham YOI Sub-Committee

Appendix 2

Agency Attendance of the Board (March 2015)

LSCB Board Date:

28th April 2014

23rd June 2014

15th September 2014

17th November 2014

16th February 2015

Agency	Number of Boards Attended	Number of Boards Not Attended	
LSCB Independent Chair	5	0	Member
Children's and Adults Services, LB Hounslow	4	1	Member
iHear	3	2	Member
Hounslow Borough Police, Metropolitan Police	4	1	Member
CWHHE, CCG	5	0	Member
Lead Member for Children, Young People and Families, LB Hounslow	1	4	Member
Community Safety, LB Hounslow	3	2	Member
Public Health, LB Hounslow	1	4	Member
Ambulance Service	1	4	Member
NHS England, Hounslow CCG	4	1	Member
Representing Hounslow Secondary Schools	1	4	Member
Youth Offending Service, LB Hounslow	2	3	Member
Hillingdon and Hounslow, Probation Service	4	1	Member

Quality and Clinical Excellence, HRCH, NHS	2	3	Member
Chief Executive, LB Hounslow	3	2	Member
Safeguarding & Quality Assurance, LB Hounslow	5	0	Member
Child Abuse Investigation Team, Metropolitan Police	3	2	Member
LSCB Training & Development Manager	4	1	Training & Development Manager
Hounslow, Kingston and Richmond, Probation Service	4	1	Member
Service and Transformation, West Middlesex University Hospital	4	1	Member
Representing Hounslow Primary Schools	2	3	Member
West London Mental Health Trust	5	0	Member
Lay Member	2	3	Member
Education and Early Intervention Service, LB Hounslow	3	2	Member
Children's Services, LB Hounslow & Vice Chair of LSCB	4	1	Member
LSCB Business Manager	5	0	Business Manager
Voluntary Sector, LB Hounslow (Joined September 2014)	2	3	Member
Safeguarding Children, NHS England, Hounslow CCG	3	2	Member
Education In Partnership, LB Hounslow	3	2	Member
NSPCC	3	2	Member
CAFCASS	1	4	Member

Nursing and Quality, PCT	2	3	Member
West Thames College	3	2	Member
Feltham YOI	2	3	Member

Appendix 3

LSCB BUDGET 2015 / 2016

Annual Income

CCG - £20,000.00

Adults Social Care - £25,000.00

Public Health - £20,000.00

Hounslow Homes - £1000.00

Probation - £1000.00

Police - £5000.00

CAFCASS - £550.00

Early Years - £4000.00

Children's Services Base Budget Contribution - £108,800.00

Total: £185,300.00

Fixed Outgoings

Salaries - £185,300.00

Training - £25,000.00

Consultancy (LSCB Chairman) - £10,000.00 x 20 days @ £500 per day

CDOP (Richmond Contribution) - £19,000.00

Chronolator Licence- £1000.00

Total: £241,300.00

Shortfall = £66,000.00

Estimate of Additional Committed Spends 2015 -2016

Serious Case Review - £15,000.00 (Estimate)

Deep Dive Themed Audit - £15,000.00 (Estimate)

Fatal Stabbing Case Review - £4500.00 x 8 days @ £500 per day + VAT

Website Development - £1,500.00 (Estimate)

Purple Book Development & Printing for voluntary sector - £4000.00 (Estimate)

Total: £39,500.00

Reserve, Total Spend & Deficit

Reserve carried over 2014/2015 = £50,000.00 (to offset Shortfall)

Estimated Total Shortfall in 2015/2016 =£60,000.00 to include a minimum of 30 days for the LSCB chairman

CSE Exploitation Co-ordinator

Public Health Additional "one-off" Funding for CSE & Vulnerabilities Coordinator = £50,000. Second year of funding still to be identified.