Hounslow Safeguarding Children Partnership

Annual Report 2020-21

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1) Foreword from the Independent Advisor and Chair

This annual report covers the period 1st April 2020 to 31st March 2021 and is the fifth annual report to cover the period since my appointment as independent chair to the children safeguarding board in October 2016. Since September 2019, under the revised guidance Working Together to Safeguard Children 2018, I am now the independent chair and advisor to the children safeguarding partnership. The annual report is the opportunity for agencies working to safeguard children to report and reflect on what has been achieved in the previous twelve months as well as on the challenges faced in ensuring safeguarding processes in Hounslow are as robust as they can be. This annual report should be read in conjunction with the partnership's business plan, which updates the partnership's objectives for the next 2 years.

The twelve month period covered by this report spanned the covid pandemic, which brought huge challenges for all the agencies who support children in Hounslow. It is to the credit of the partnership that despite the pressures that the work programme for the partnership continued to be delivered during the year with minimum disruption.

A key function of the safeguarding children partnership is to provide support and challenge to ensure that individual agencies hold themselves to account for their performance as well as taking collective responsibility for the performance of the safeguarding system as a whole. The partnership continues to have committed membership from partner agencies on its various sub-groups. These sub-groups are the engine room of the partnership and ensure the successful implementation of the partnership's policies and assurance role. During 2020/21 the partnership and the sub-groups met on-line which enabled continuity of business and good attendance but to some extent may have inhibited full contributions from some members who are more comfortable in face-to-face settings.

The Executive agreed a reduced number of key priorities for 2019/21 in April 2020 due to the pandemic pressures. These priorities were safeguarding adolescents, inter-familial child sexual abuse and neglect as well as a re-emphasis on the commitment to ensure that agencies deliver on their core safeguarding duties so delivering better outcomes for children and their families. Two additional priorities of improving collaboration with adult services providers and the mental health and wellbeing of children originally identified in 2019 were left to other work streams.

Sir Alan Wood's report (2016) on multi-agency safeguarding arrangements set up the children safeguarding partnerships with shared accountability for safeguarding clearly allocated on an equal basis to the three lead statutory agencies (the Council, the NHS, and the Police). His follow up review report (2021) introduced the concept of safeguarding partnerships producing an annual assurance statement as to the state of health of the local safeguarding arrangements. In the forward to last year's annual report, I set out a number of issues where, as the independent advisor and chair to the partnership, I was not fully assured. These issues were prioritised for challenge and scrutiny during the year to enable the multi-agency partnership to seek assurance that there were robust plans to improve performance and that these plans were being actively monitored. These issues were identified through the partnership's programme of multi-agency audits as well as being identified through external regulatory bodies. The issues identified for more work and scrutiny were Neglect, Safeguarding Meetings, Timeliness of Assessments, Quantity and Quality of CFANs coming into the MASH, Serious Youth Violence, Child Sexual Abuse, Feltham YOI safeguarding issues and Domestic Abuse. The body of this annual report contains detailed information on the progress made during the year on each of these issues.

For this annual report, I am providing a statement of assurance to the partnership executive which will highlight areas where there is evidence that progress has been made towards achieving assurance and likewise identify those areas where there has been insufficient progress leading to a lack of assurance. There is no national format for producing an assurance statement and there is always the health warning that a service or function can appear to have

robust safeguarding practise but a serious incident involving a child can throw doubt on this assessment overnight.

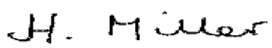
The safeguarding children partnership does not operate in isolation from other partnership structures within Hounslow as its agenda in safeguarding children has key overlaps with the Safeguarding Adults Board, the Community Safety Partnership and the Health and Wellbeing Board among others. It is essential that strategy, policy and protocols as well as operational service delivery are all “joined up” to ensure that vulnerable children and adults do not fall through any gap in provision. In order to facilitate this joined up agenda, the chairs and/or key strategic officers of these key partnership boards have met during the year to ensure coordination of effort and avoidance of duplication. Key agenda topics have been the systemic review of serious youth violence and how adult and children’s services can work co-operatively in the MASH. The Community Safety Partnership leads on domestic violence, harmful practices e g female genital mutilation and modern slavery.

Education is the acknowledged fourth key partner in Hounslow’s safeguarding arrangements. Regular meetings with head teachers and designated safeguarding leads for schools were paused during the covid crisis but engagement has continued through the efforts of education representatives on the partnership board together with the circulation of partnership information to the designated leads. The 2020 education safeguarding audit was also paused due to Covid-19, but schools have continued to post their audits as time allowed during the year. The education audit will be re-launched in January 2022.

Issues that still present challenge to the success of the partnership include the unequal funding arrangements, with the local authority still carrying the heaviest burden despite accountability for safeguarding now falling equally on health commissioners and the police.

This annual report will be presented to the Health and Well-being Board and the Children’s Scrutiny Panel for information and there is an expectation that agencies will take it to their appropriate board or key governance structure.

Hannah Miller OBE,



Independent Chair and Advisor
Hounslow Safeguarding Children Partnership

2) Statement of Assurance from HSCP Independent Advisor

Areas Working Towards Achieving Positive Assurance

Partnership Members Views

During the year I held one to one meetings with the majority of partnership members to take a temperature check on how agencies perceived how the partnership was working. The picture emerged of an inclusive partnership with good inter-agency working relationships and an open, transparent approach to challenge. Members who sit on neighbouring partnerships compared the Hounslow partnership very favourably.

This assessment was reinforced at the independently facilitated Challenge Day held in March 2021 where members were asked to judge the effectiveness of the partnership. Members felt assured that the safeguarding system in Hounslow is safe, effective, and responsive to emerging need by acting on learning identified. It was agreed that more should be done to ensure the partnership can easily evidence improved outcomes for children and their families in order to provide regular statements of assurance.

Statutory Annual Reports

With one exception, the annual reports were presented to the partnership board for challenge and scrutiny. None of the reports highlighted any specific safeguarding risks or concerns but the partnership was very aware of the pressures agencies were under in producing reports and more importantly continuing to prioritise safeguarding of children in difficult circumstances.

Covid Assurance

The partnership regularly monitored the impact of covid pressures on the delivery of safe services to children and their families. I was assured that despite redeployment of staff and reduction in capacity due to sickness and self-isolation that overall, there was limited disruption to operational practice. Safeguarding was clearly prioritised by all partner agencies during the pandemic.

Multi-Agency Audit Programme

An important part of the assurance process is external audit. The partnership has developed a dynamic approach to audit targeted at safeguarding issues specifically identified within Hounslow as needing improvement and which can be linked to improved strategic approaches. During the year an audit was independently commissioned on inter-familial child sexual abuse together with systemic reviews of serious youth violence and domestic abuse. Both of the latter reviews included case audits. Action plans have been developed and are being progressed and monitored through partnership sub-groups. 7-minute briefings are produced to help with the cascade of learning to front line practitioners and learning from reviews is incorporated into multi-agency training.

Rapid Reviews

Four rapid reviews were held during 2020/21. All four review reports with recommendations were positively received by the National Panel giving assurance that the process is working well in Hounslow. Two cases of long- term chronic neglect was escalated to local safeguarding practise reviews to be completed during 2021/22.

Safeguarding meetings

I am assured that the action plan following the 2019/20 audit of safeguarding meetings has made good progress with evidence that multi-agency attendance at meetings has greatly improved despite the pandemic pressures. The new Child Protection (CP) Conference model was agreed by the partnership and rolled out. The separation of the roles of CP Conference Chair and the IRO role should encourage more challenge to the contributions of the safeguarding networks and improved decision making. This is an area to be earmarked for a future external audit in order to provide full assurance.

Timeliness of assessments

This issue was highlighted by an Ofsted focused visit in January 2020. The partnership has monitored improvement plans from Children's Social Care and received assurance that timescales for assessments are back on track despite the pandemic pressures.

Inter-familial Child Sexual Abuse

The partnership self-assessment of practice in 2019/20 using the Ofsted inspection framework concluded that the partnership could not be assured that risk associated with interfamilial child sexual abuse was consistently and effectively identified or responded to in Hounslow. An in-depth audit of ten cases was independently commissioned in 2020/21 to consider multi-agency practice. The audit identified improved practice in real time as opposed to historic practice. Most cases were judged to be Good based on the current protection plans. Hounslow was judged to be in line with the national picture identified in the JTAI overview report published in February 2020. A training programme based on the audit findings is being rolled out to front line staff and managers during 2021/22 with a future audit planned for 2022/23. This issue will remain as a priority for the partnership until the training programme has been completed and practice has been re-audited.

Feltham Youth Offending Institute- Safeguarding Issues

I reported last year that Feltham YOI had been issued with an Urgent Notification following an HMIP inspection which identified a rise in assaults and violence, a restricted regime for boys due to staff shortages and high levels of inappropriate referrals to the LADO from an ineffective internal safeguarding team. The FYOI sub-group of the partnership has monitored the implementation of the action plan delivering on the inspection recommendations, providing a high level of challenge and support to the institute that was commended by the Governor at the partnership March 2021 Challenge Day. This included a Good Order or Discipline (Rule 49) audit in October 2020. Follow up scrutiny visits by regulators during 2020/21 confirmed that substantial progress has been made on all recommendations and the Urgent Notification has now finally been lifted. This provides a good level of assurance for the partnership but one that needs to be kept under careful review.

Areas Requiring more Assurance/Evidencing of Outcomes

Data Provision and Analysis

I have raised the issue of the partnership not receiving timely analysed data from all partners in a number of previous annual reports. Pursuing this issue has been very time-consuming and frustrating for the partnership Service Manager and the Chair of the Safeguarding Effectiveness Sub-Group. The Safeguarding Effectiveness Sub-Group has developed a revised dataset, but it is still proving difficult to populate it. This issue pre-dates the Covid-17 pressures on agencies.

Good quality data is a pre-requisite for easy identification of issues that may require early partnership intervention. This issue has been escalated to the Executive Board for resolution.

Voice of the Child/Outcomes for Children

Progress has been made by the partnership in capturing the voice of the child through various Children's Social Care initiatives and some of the partnership audits e.g., auditors spoke to the boys in Feltham YOI about what changes they consider would improve the isolation regime. I am proposing that in 2021/22 the partnership benchmarks how the voice of the child is heard across all the member agencies so that a safeguarding engagement strategy/action plan can be developed to provide greater assurance in this important area and is outlined in the HSCP Strategic Safeguarding Children Plan 2021/23.

Neglect

Neglect has been a key priority in the 2019/21 business plan with the strategy and training plan being refreshed and re-launched in January 2020 along with a partnership mandate for agencies to use the Quality of Care Assessment tool. There were two multi-agency audits prior to the re-launch with disappointing results, which provided a low level of assurance. A third audit is scheduled for autumn 2021. There have been two long -term chronic neglect cases escalated to Local Child Safeguarding Practice Reviews in the year which are due to be published later in 2021. I am concerned that improving the multi-agency practice in neglect cases has proved to be such a challenge for Hounslow despite the energy and resources devoted to it by the partnership.

Quantity and Quality of CFANS/Threshold Issues

The Hounslow Threshold for Assessment and Referral Protocol document for triggering a social care assessment was updated in 2021 and has been rolled out across the safeguarding system but it is too early to say what effect this will have on reducing inappropriate referrals and improving the quality of the information provided by partner agencies. An external desk- top audit of 50 contact referrals not accepted for a Social Care assessment is in the process of being commissioned. The findings from this audit can identify where the issues lie and enable training to be appropriately targeted.

Consistency of social work practise

Ofsted focused visits have not found any child at risk of serious harm but have commented that practice is not always consistent across all social work teams. Inconsistency in social work practice and decision-making has also been identified in partnership audits during 2020/21. I will be looking for additional assurance from the internal quality assurance audits conducted in Children's Social Care as well as the partnership's regular monitoring of improvement plans to meet Ofsted recommendations.

Serious Youth Violence

The externally commissioned systemic review of serious youth violence set out a blueprint for a multi-agency strategic approach to safeguarding adolescents that was endorsed by the partnership in October 2020. A partnership sub-group has been set up to progress the recommendations of the review and implement the strategy. It has already been identified that there are challenges in getting the information from agencies that will enable the sub-group to progress implementation and provide reassurance of effectiveness to the HSCP Partnership Board and Executive Board. This issue is being escalated to the Executive Board for hopeful

resolution. The need for assurance is particularly acute given the emergence of a formally recognised gang in the borough.

MACE

There were a number of recommendations in the systemic review of youth violence concerning MACE. Following the review, oversight of MACE initially fell to the Safeguarding Effectiveness Sub-Group. The new Adolescent Oversight and Monitoring Sub-Group of the partnership has now taken on the functions of a Strategic MACE. I do not feel assured that the operational MACE has fully implemented the systemic review recommendations. The new terms of reference have not been signed off and there are issues with multi-agency representation.

Domestic Abuse

The systemic review of domestic abuse highlighted examples of positive multi-agency working in domestic abuse cases where there were children in the family. It highlighted the importance of collaborative working across agencies together with joint responsibility in safeguarding planning for children exposed to domestic abuse. Recommendations included the need for professionals to "Think Family" and for specialist training in domestic abuse for those working with families. The HSCP will require formal assurance from the Community Safety Partnership that any recommendations which fall within their responsibility are being implemented and outcomes delivered for children.

Modern Slavery and Harmful Practices (FGM, Forced Marriage, Faith Abuse)

The Community Safety Partnership has historically taken the strategic lead on these issues and had agreed to provide an annual report to the Children's Safeguarding Partnership. This regular reporting has fallen away in the last few years partly through Covid-19 pressures and partly to the review of strategic priorities by the Community Safety Partnership. Given the importance of these issues to the safeguarding of children, these reports must be reinstated on a regular basis to provide assurance that children are not being placed at risk of harm and that appropriate prevention strategies are in place.

CAMHS

The partnership was not fully assured by a paper in June 2020 that children were necessarily safe while waiting for a CAMHS service given waiting list times, low staff numbers and a general lack of capacity. A follow up paper was delayed to June 2021 due to Covid-19 pressures on clinicians and provided only partial assurance in that CAMHS was making best use of its limited resources but that there were still issues around waiting times and capacity made worse by the increase in demand due to the pandemic. Partnership concerns were escalated to the Executive Board and I wrote to the CEO of West London Mental Health Trust stating our concerns and requesting a regular quarterly update report for the partnership. Ofsted also picked up on CAMHS capacity issues during their last Focused Visit of Children's Social Care in July 2021.

Home Schooling

There has been added emphasis on home schooling as a result of numbers increasing during the pandemic. Concerns around decision making on eligibility for home schooling as well as the role of the Education Welfare Service was highlighted in a rapid review of a long-term neglect case which is now the subject of a Local Child Safeguarding Practice Review. The National Panel have a particular interest in this case as they are doing their own national deep dive into

15 notified safeguarding cases where home schooling is a factor. A partnership priority for 2021/23 is vulnerable children in education, which includes elective home schooling.

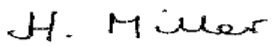
Early Years

The partnership received a paper on the Year 1 progress of the Early Help Hub, which has received funding for another year from the council. The Hub does not appear to have achieved its key objective of diverting referrals from the Front Door of the MASH and further assurance is required as to how partners will deliver the prevention agenda in order to support families and stop them coming into the child in need/child protection arena.

Private Fostering

It was disappointing that the usual annual report on Private Fostering was not presented to the partnership for scrutiny and challenge in 2020/21. Receiving this annual report has been a priority for the current year in order that the partnership can receive assurance.

Hannah Miller OBE,



Independent Chair and Advisor
Hounslow Safeguarding Children Partnership

3) Introduction

Keeping children safe is a shared partnership responsibility, with each agency fulfilling their role to promote the welfare and safeguarding of children in Hounslow. Effective partnership working requires each agency to commit resources to deliver strategic and operational priorities under Working Together to Safeguard Children (WTSC) guidance, London Child Protection Procedures and local safeguarding protocols and guidance.

The report reviews the activity of the Hounslow Local Safeguarding Children Partnership (HSCP) over the 2020/21 financial year.

Following the requirements outlined in the WTSC 2018 guidance, Hounslow's Multi-Agency Safeguarding Arrangements (MASA) were published in June 2019 and have been operational since then. A full review of how well the partnership had functioned during this period was due to be undertaken at the end of 2020/21 but was postponed due to Covid-19. From May 2021 the Partnership Executive Board has implemented s strategic an effectiveness and assurance monitoring framework to ensure that the HSCP has effective arrangements in place, there is strong leadership and oversight, and the partnership's focus remains on seeking assurance that children and young people are safeguarded.

The HSCP Business Plan 2019/21 sets out the strategic commitment of the partnership in making its vision a reality and formed the basis of its work over the last two years**,** ensuring that the partnership continues to oversee and drive improvements.

The two-year business plan has focused on key areas of safeguarding which were identified by either local need following quality assurance and learning activity or responding to national safeguarding agendas.

Themed priorities for 2019/21:

1. Safeguarding adolescents in the home and the community (linking with contextual safeguarding)
2. Neglect
3. Child Sexual Abuse (Focus on interfamilial abuse)
4. Improving collaboration between Children's and Adults' Service providers
5. Mental health and emotional wellbeing

In April 2020 the Executive Partnership Board agreed to reduce its priorities for the coming year to continue to focus on safeguarding adolescents and neglect and to progress its work on Child Sexual Abuse and the safeguarding element of Improving Collaboration between Children's and Adults' Service Providers and Mental health and emotional wellbeing could be addressed in other workstreams.

The evidence to support the analysis of the partnerships progress over the last year and the ongoing work which has been identified has been collected from the activity of the Board, sub-groups, training evaluation, learning from the multi-agency case reviews and audits, as well as assurance and monitoring activities.

Covid-19

Since March 20219, Covid-19 has been and continues to be the backdrop for all services and agencies to navigate whilst ensuring continued delivery of core safeguarding functions.

Undoubtedly this has at times created service pressure and a need to adjust priorities and focus of areas of work. From April the partnership closely monitored the impact of Covid-19 on the delivery of safeguarding responsibilities to families and children in Hounslow ensuring that contingency planning from key partnership agencies continued to prioritise safeguarding during the pandemic, despite redeployment and reduction in capacity.

The most disruption was within health services some of whom were redeployed to manage the pandemic however key safeguarding functions were maintained. Overall, all agencies adapted well and maintained business as usual function utilising technology to ensure there was limited disruption to operational practice or the partnerships work programme.

4) Hounslow's Context

Population

Hounslow is the 9th largest London Borough (out of 33) in terms of geographical area and current estimates show Hounslow to be 16th largest by population (271523). According to Greater London Authority (GLA) projections the total population of Hounslow is projected to grow by approximately 4,000 per year until 2024 and then continue to rise but at a slower pace – at approximately 1000 per year onwards until 2041; the population aged 0-18 is expected to grow by approximately 600-700 per year from 2020 until 2024. The population of 0-18-year olds is expected to decline onwards.

The Office of National Statistics midyear population estimates for 2019 shows that in Hounslow the population age 0 to 18 years is approximately 68,213 and makes up 25.1% of the total population. This proportion is similar to the London average (23.7%).

GLA projections show that in 2020, the size of the 0-4 years age group was expected to be 20037 (7.2% of the population), in 2021 is expected to be 19,867 (7.0% of the population) and in 2026 is expected to be 19571 (6.5% of the population).

Overcrowding, where the household has one fewer room than required, was the same in Hounslow in 2011 (22%) as in London. The wards with the most overcrowding were Hounslow Central (36%) and Hounslow Heath (34%) and the least overcrowding in Hounslow South (13%) and Chiswick Riverside (13%).

In 2011, there were 51,533 dependent children under 16 years living in Hounslow. Out of the 94,902 households, 5.5% have dependent children with no adults in employment.

5) Governance & Accountability

Scrutiny of HSCP Annual Report 2019/20

The annual report for 2019/20 was written to comprehensively reflect the work undertaken for the year and approved by the Partnership in September 2020. It was disseminated to all partners and published on its website. The report went through a further governance and scrutiny process and was shared with the Health and Wellbeing Board. The report was not reviewed by the Children and Young People Scrutiny Panel in 2020 as it had been in previous years due to a change in focus of the panel. Partner agencies are expected to ensure the report is considered by the executive leadership groups and scrutiny functions in their organisations.

Governance of Partners Reporting to the Board

Annual reporting cycles for partner agencies have become a part of the Boards forward planning agenda and are considered for oversight and challenge. In 2019/20 partnership reported that there had been a decline in agencies submitting their safeguarding annual reports for discussion. As a result of challenge from the Independent Advisor there was an improvement in the submission of reports from its partner agencies which has supported the partnership to be assured about core safeguarding practice in all of its member organisations.

In the last year the reports which have been considered include:

- Feltham YOI Managing and Minimising Physical Restraining Annual Report 2019/20
- Children Missing Education Annual Report 2019/20
- Elective Home Education Annual Report 2019/20
- Traveller Education Annual Report 2019/20
- HRCH Safeguarding Children Annual Report 2019/20
- WL NHS Trust Annual Report 2019/20
- Chelsea and Westminster Hospital Safeguarding Annual Report 2019/20
- Chelsea and Westminster Hospital Domestic Abuse Report 2019/20
- Chelsea and Westminster Hospital Learning Disability and Transition Annual Report 2019/20
- CCG NWL Safeguarding Annual Report 2019/20
- CDOP Annual Report 2019/20
- Child Protection Chairs Annual Report 2019/20
- Independent Reviewing Officer Annual Report 2019/20
- LADO Annual Report 2019/20

The partnership did not receive an annual report in relation to Private Fostering which has impacted oversight of the work being undertaken by the service.

Relationship with Strategic Boards

As outlined in the MASA, partnership working between strategic Boards has continued through the Strategic Chairs meetings to ensure that safeguarding children and adults is considered, prioritised and cross cutting priorities are jointly achieved. Two meetings have taken place in the last year which focused on:

- Serious violence including serious youth violence
- Joint working between adults and children's service
- Safeguarding of vulnerable adults including cuckooing

There are increasing crossovers of responsibility and a joint coordinated response between the HSCP and the Community Safety Partnership (CSP) to address safeguarding issues, particularly youth violence, exploitation and domestic abuse. The HSCP has continued to actively participate in all relevant groups and workstreams led by the CSP, to ensure strategic responses are collaborative and effective.

6) Challenge, Assurance, & Scrutiny

The work to improve the partnerships challenge and scrutiny function has continued to develop and expectation set by the Independent Advisor has been further embedded and supported by the increased oversight of the HSCP Executive Board.

Challenge Day 2021

At the HSCP Challenge Day in March 2021 members were asked to judge the effectiveness of the partnership and how assured they were that the safeguarding system was safe and effective. Overall, members judged the partnership to be effective and collaborative in its function and acting as a leadership team. There is clear direction and pace to achieving the objectives of the business plan and members felt assured that the safeguarding system was safe, effective, and responsive to emerging need by acting on learning identified.

It was identified that there was a need for the partnership to continuously challenge themselves on addressing gaps and areas of improvement and that there was more work to do to ensure that it could easily evidence its assurance and effectiveness to be able to provide regular statements of assurance.

Particular areas of focus that were identified as needing further discussion were:

- Early Help continuing to be everybody's business.
- Professional confidence in decision making and managing risk outside of the context of Children's Social Care intervention.
- Support for young people, particularly those who have been exploited and who do not meet the threshold for Adults Services.
- Consistent multi-agency attendance at operational safeguarding meetings
- Intelligence and evidence-based strategic decision making
- Greater focus on the voice of families, children and young people

For part of the session the HSCP and Hounslow Safeguarding Adults' Board (HSAB) came together to explore the collaborative safeguarding response to vulnerable adults who have children and children who have vulnerable parents as well as discussing the safeguarding of children transitioning into adulthood outside of contextual safeguarding.

It was identified that there was a good uptake of safeguarding children training by Adults' Services and there had been positive improvement in Children Social Care (CSC) actively trying to identify young carers with the support of Adults' Services.

Further work is needed to reframe the use of the 'Think Family' language and the emphasis on children and an 'All Age Think Family' approach would reshape the conversations between professionals.

The area of Transitional Safeguarding is wider than children in care transitioning to Adults' Services. Good work is being through joint panels to consider the needs of children transitioning with ongoing social care needs and those who have been identified with Special Educational Needs and Disabilities (SEND). Further work is required to ensure that needs are identified earlier and there is a balance between support and empowerment and working beyond statutory responsibility.

Scrutiny and Oversight

The partnership has continued to challenge performance and scrutinise improvements across its partners organisations considering the following areas:

- Statutory safeguarding delivery during Covid-19 (Activity reports and verbal feedback)
- Covid-19 recovery plans (action plans and verbal feedback)

- Domestic abuse rates and responses during Covid-19 (Activity reports and verbal feedback)
- CAMHS service delivery (Assurance report)
- Use of Police Protection Audit (Audit overview report)
- Children's Social Care Improvement (Improvement Plan progress update)
- Ofsted Focused Visit 2020 progress (Assurance report)
- Changes to Child Protection Conferences and expectation of the multi-agency system (Overview report and action plan)
- Reduction of Police attendance at Review Child Protection Conferences (Assurance report)
- Police and Community Safety response to Domestic Abuse (Joint position report)
- Early Help Hub Year 1 progress (Presentation)
- Feltham YOI HMIP Scrutiny Visit Outcome (Report)
- Multi-Agency Safeguarding Meeting Audit 2020 progress (Progress and assurance report)
- Community Safety Partnership Violence Reduction Plan (Action plan)
- Placement of asylum seekers in North West London (Letter of concern and discussion)
- Child Sexual Abuse Audit 2020 findings (Audit report)
- HSCP Escalation Policy review (Policy document)
- HRCH MASH timeliness monitoring (Assurance reports)

Particular Areas of Scrutiny and Challenge Requiring Ongoing Monitoring

CAMHS Service Delivery

Following an assurance paper to the partnership in June 2020 about CAMHS service delivery and the impact on children who were known to safeguarding services, the partnership raised some concerns about referrals, waiting list times, low staff numbers and lack of capacity some of which had been impacted by Covid-19 and members did not feel wholly assured that children were safe whilst waiting for support.

It was agreed that a subsequent assurance paper would be presented in 6 months' time however due to clinical commitments during the pandemic the report was delayed until June 2021. The report provided partial reassurance and continued to highlight that little improvement in waiting list times and capacity had been made. As an outcome of the report and escalation from the Local Authority to the HSCP Executive Board, quarterly monitoring reports have been requested on progress made against areas of concern to ensure that the partnership is assured that there are measures in place to appropriately safeguard children who are on waiting lists. It was agreed as an additional assurance measure a mapping exercise would be completed of children on the current waiting list to check what services that they are known to ensure appropriate support was being offered.

Appropriate use of Police Protection

The partnership was informed of concerns around young people being place in timely and suitable accommodation when taken into Police Protection (PP). There were some concerns about the conclusion of plans once protection ends and, in some cases, a lack of understanding with newer Police Officer about the requirements of legislation and ensuring it was applied properly and concluded effectively. As a result, a joint review was undertaken between Police and Children's Social Care (CSC) to establish a consistent approach and application of the legislation and to ensure collaborative working between agencies to identify the most appropriate placement.

The findings of the review are reported in section 10.

Children's Social Care Improvement and Ofsted Focus Visit 2020 progress

The Focused Visit found some improvements in areas which were identified as requiring improvement in the ILACS inspection in 2018. As a result of the visit, CSC developed Service Level Improvement Plans to drive the overarching Departmental Plan and address areas of improvement such as the timeliness and quality of assessments, modification of the case audit tool to focus on outcomes and the child's lived experience, partners contribution to safeguarding meetings and to monitor any issues of compliance.

Regular reporting of progress continues to be shared with the partnership.

7) Safeguarding in Hounslow

Multi-Agency Safeguarding Hub (MASH)

- There were 20,425 contacts recorded in LCS between 01 April 2020 and 31 March 2021, of these, 1,194 (5.8%) were considered for MASH checks, which shows a reduction of 1.5 percentage points on 2019/20 when it was 7.3%.
- The most common reason for contact being made was Early Support (24.1%) followed by family breakdown/crisis (16.1%) and domestic abuse (15.4%)
- The top three referring agencies continue to be Police (35.3%), Health (17.8%) and Education providers (12.1%).

MASH	2020/21	2019/20	2018/19
No. of AMBER and GREEN contacts considered for MASH checks	1194	1378	1410
% of contacts considered for MASH checks*	5.8%	7.3%	7.5%
% of contacts received from agency - police	35.3%	34.0%	35.0%
% of contacts received from agency - education	12.1%	14.7%	14.8%
% of contacts received form agency - health	17.8%	17.7%	17.3%
% of contacts received from agency - adult social care	7.1%	7.1%	8.2%
% of contacts received from agency - probation	2.0%	5.6%	4.0%
% of contacts received from agency - individual	7.3%	6.4%	6.0%
% of contacts received from other agencies	4.3%	11.0%	10.7%
The most frequent reason for contact	Early Support (24.1%)	Family Breakdown/Crisis	domestic violence
% of contacts RAG rated RED following MASH checks	21.9%	28.9%	33.0%
% of contacts RAG rated GREEN following MASH checks	17.0%	52.7%	50.7%
% of checks for all agencies completed within 24 hours	-	-	68.4%
% of checks for all agencies completed within 48 hours	-	-	71.3%

*Percentage of all contacts received (Red, Amber or Green)

Front Door

- The percentage of repeat referrals received in 2020/21 was 22.1%, an increase from 17.4% in 2019/20 and 18.1% in 2018/19.2019/20 was 17.4%.
- The percentage of referrals received that progressed to a multi-assessment during the year was 87.1%, this follows a continuing downward trend since 2017/18.
- The Children in Need Census outturn for 2019/20 shows that 96% of assessments completed in the year were completed within 45 working days. This is an improvement from an outturn of 66% in 2019/20.
- The final percentage of ICPCs held within 15 working days during 2020/21 was 90% and shows a improvement in performance from 81% in 2019/20.

Front Door	2020/21	2019/20	2018/19	2017/18	2016/17
No. of contacts completed	20425	18,958	18,942	26,759	30,316
% of contacts completed that led to a referral	13.1%	15.3%	17.2%	9.6%	8.9%
% repeat referrals started within the last 12 months	22.1%	17.4%	18.1%	15.3%	21.4%
% referrals completed which led to a multi assessment	87.1%	90.0%	91.2%	96.4%	94.6%
% of multi assessments completed within 45 working days	96%	66%	73.5%	79.2%	77.9%
% multi assessments completed with an outcome of NFA	36.5%	47.5%	47.8%	44.4%	44.6%
No of Section 47s started	1103	855	818	693	581
No of completed S47s with an outcome of ICPC	472	293	306	188	181
% of completed S47s with an outcome of ICPC	39.3%	41.8%	36.9%	30.2%	33.1%
% ICPC occurred within 15 working days of start of S47 enquiry	90%	81%	66.6%	84.6%	77.7%

Child Protection

- The final percentage of children becoming the subject of a Child Protection plan for a second or subsequent time during 2020/21 was 24.6% (44 children) and shows an increase on the percentage of 18.5% from 2019/20.
- The final percentage of Child Protection Plans ending after 2 years or more during 2020/21 was 0.8% (2 children)
- The percentage of children with a current CP Plan lasting 2 years or more as of 31 March 2021 was 2.4% (6 children). This is a reduction from 0.0% (0 children) as of 31 March 2020.

Child Protection Plans (latest category)	2020/21	2019/20	2018/19	2017/18	2016/17
Number of CP Plans for Emotional Abuse	122	73	81	78	104
Number of CP Plans for Physical Abuse	10	11	5	7	13
Number of CP Plans for Neglect	110	93	141	133	132
Number of CP Plans for Sexual Abuse	6	10	18	11	10
Number of CP Plans for children with disabilities	16	4	14	21	10
Percentage of children becoming subject of a plan for a 2nd or subsequent time	24.6%	18.5%	14.1%	15.6%	13.4%
Number CP plans ended after a period of 2 years or more	2	25	19	15	6
Percentage of Child Protection Plans ending after 2 years or more	0.8%	8.4%	6.5%	5.2%	2.4%
Number of children with a current CP Plan lasting 2 years or more	6	0	11	15	8
Percentage of children with a current CP Plan lasting 2 years or more	2.4%	0%	4.5%	6.6%	3.1%

Comparator Data for Child Protection per 10,000

Child Protection Plans	2020/21	2019/20		
	Hounslow	Hounslow	England	Outer London
Number of:				
Children who became to subject of a CP plan	317	238	66,380	5,510
Ceased to be on a CP Plan	254	297	67,910	58,10
Rate per 10,000 for:				
Children who became to subject of a CP plan	48.2	36.5	55.2	43.1
Ceased to be on a CP Plan	38.6	45.5	55.7	45.4

Looked after children as at the year-end

- There were 255 looked after children as at 31 March 2021 which was 11 less children than the previous year. Of the 255 LAC as at 31 March 2021, 91 (35.7%) were placed in residential care, this is similar to the outturn from 2018/19.

- Of the 255 LAC as at 31 March 2021, 9 children (3.5%) were accommodated under Section 20 and under the age of 14 years.

Safeguarding Children Looked After	2020/21	2019/20	2018/19	2017/18	2016/17
The number of CLA at the year end	255	269	278	248	250
Number of CLA in residential care	91	89	91	66	40
Number of CLA under police protection in LA accommodation	0	0	0	0	4
Number of CLA accommodated under Section 20 under the age of 14	9	16	5	18	17

Comparator Data for Looked After Children per 10,000 as at the year-end

		Rate per 10,000 children		
Year LAC	Number LAC	Hounslow	England	Outer London
2013/14	317	52	60	48
2014/15	294	48	60	47
2015/16	280	45	60	47
2016/17	250	40	62	45
2017/18	248	39	64	44
2018/19	278	43	65	46
2019/20	269	41	67.0	45
2020/21	255	39.1		

Children missing from care

- The number of children reported missing from care in 2020/21 was 60 this shows an increase of 1 children compared to 2019/20 when it was 59.

Missing Children	2020/21	2019/20	2018/19	2017/18
Number of Missing Children (episode in year)	60	59	40	28
Number of Missing Episodes (total episodes in year)	353	315	135	152
Number of children missing at 31 March	0	0	0	0
% of children missing who were subject to CSE at end	0	0	0	0

Children missing from home

- The number of children reported missing from home dropped to 100 children during 2020/21, from 109 in the 12 months to 31 March 2020.

Missing Children	2020/21	2019/20	2018/19	2017/18
Number of Missing Children	100	109	155	1813
Number of Missing Episodes	181	245	297	267

8) HSCP Targeted Priorities 2019/21

Below, the report outlines the progress made under each of its priority areas and its core business throughout the last year, what needs to be achieved in the coming year, and how practitioners' views and the voice of the community and young people have been sought.

Priority 1 - Safeguarding adolescents in the home and the community (linking with contextual safeguarding)

Outcome 1 - *A strategically led, intelligence based multi-agency system is in place that is responsive to the safeguarding needs of vulnerable adolescents, so that they can be diverted from the risks posed to them and achieve their potential.*

Outcome 2 - *All of Hounslow's multi-agency workforce recognise the early and emerging signs of future risks for young people and respond with preventative interventions.*

The partnership has focused its efforts on developing a local, evidenced based position about the profile of young people who are at risk, from factors outside of the home environment, determining what is working well and where improvements must be made.

Achievements in 2020/21

- Completion and publication of the systemic review into Serious Youth Violence (SYV) and development of the action plan responding to recommendations.
- Scoping exercise undertaken to baseline response to adolescent risk outside of contextual safeguarding and extra familial risk to support development of the Adolescent Safeguarding Strategy and implementation plan.
- Strategic MACE disbanded and absorbed into the Safeguarding Effectiveness Sub-Group to ensure appropriate challenge and scrutiny of Operational MACE.

Activity for 2022/21:

- Agreement, launch and implementation of the Adolescent Safeguarding Strategy.
- Adolescent Oversight and Monitoring Group to be established and year 1 of associated workplan delivered.

Systemic Review of Serious Youth Violence

The findings and recommendations of the SYV systemic review undertaken by Keith Ibbetson were accepted and agreed by the partnership in October 2020. The learning identified from the review was published on the partnership's website HSCP Serious Youth Violence Systemic Review and shared with the National Panel. In addition to the learning and recommendations for partner agencies, three recommendations relating to governance, accountability and

organisational systems were identified and a leadership report outlining the findings was accepted and used by organisational leaders to realign responsibilities and oversight.

Overall, the review found that Hounslow did not have an entrenched cohort of young people perpetrating serious violence. There was learning identified for each agency that was included in the review and a particular theme was challenging services to work with young people outside of statutory boundaries and ‘’hold onto’’ young people and families despite periods of lack of engagement.

An action plan incorporating a total of 22 recommendations was developed and its outcomes along with the learning from the review were being used to develop the Adolescent Safeguarding Strategy throughout 2021/22.

Adolescent Safeguarding Strategy Development

In November partnership agreed to develop a strategy for adolescent safeguarding which focused on the services for those who require additional support services to safeguard them and to make a successful transition to adulthood.

A scoping exercise was undertaken across partner agencies known to be working with adolescents to baseline current need and inform the priorities. Information was submitted by a number of agencies and detailed responses were received from Woodbridge Park Education Centre, Youth Offending Service, Adolescent Support Team and Public Health. With the exception of speech and language therapy, health services provided limited information, some viewing their role as identifiers and referrers of adolescent safeguarding difficulties as opposed to service providers.

Analysis of the information evidenced that serious youth violence (offending, criminal exploitation, knife crime), sexual harms (sexual abuse and CSE), broken and disrupted educational journeys (poor attendance, managed moves, internal and permanent exclusions, achievement below potential), special needs due to behavioural difficulties and adverse childhood experiences caused by abuse and neglect required the most significant focus.

Once agreed the strategy will establish the vision and aspirations for adolescent safeguarding service provision in Hounslow and aim to achieve:

- Improved understanding of risk and vulnerability
- Outline the current picture of service provision to include strengths in services and opportunities for improvement such as;
    - Better ways of understanding adolescent behaviour, need and risk
    - Better understanding of extra-familial risk and ways of responding
    - Improved ways of working based on good practice and research
    - Better coordination and planning of services, eliminating duplication
    - Better pathways between services to improve access
    - Better use of key locations for service delivery such as schools and colleges
    - Better service user involvement in planning and delivery of services
- Provide a framework for the monitoring progress against and measure performance

Criminal Exploitation (CCE) and Missing Children

Child Criminal Exploitation

The Safeguarding Effectiveness sub-group which has responsibility for the delivery of the partnership business plan and themed priorities. As part of its work in safeguarding adolescents, it has ensured oversight of the of the multi-agency response to young people at risk of exploitation by challenging and scrutinising the work of the MACE Panel.

Multi-Agency Criminal Exploitation Panel (MACE)

Whilst the previous report from 2019-20 suggested that there would be little change to the operation of the MACE panels in Hounslow, following the review into Serious Youth Violence and the recommendations by the reports' author, the MACE panels have been significantly reviewed over the past year.

The Strategic MACE ceased operation in November 2020 with the responsibility and oversight of the Operational Mace moving to the Safeguarding Effectiveness sub-group in December 2020 and then in August 2021 the newly formed Adolescent Oversight and Monitoring Group (AOMG).

Operational MACE continues to be jointly chaired by the Police and Children's Social Care, with attendance from a range of partners, e.g., Education, Health, YOS, etc. A newly formulated agenda came into action in January 2021 and has been largely welcomed by all as being more accessible and easier to determine information. The difference is that the agenda now contains all pertinent information, the action plan and the child profile for each individual child open in one document. This has meant people are a lot clearer on the actions and the progress that is being made for each child.

Operational MACE has reviewed its operating model, moving away from primarily looking at individual cases (although this is still an important part of the MACE function) to include a more holistic view of risk and exploitation, through the mapping and disrupting of locations and/or cohorts of concern in the Local area. The review and development of the MACE continues to meet the needs of local young people at risk of exploitation, serious youth violence and gang affiliation across the borough. This has included a determined development of working relationships across the partnership including wider teams in the Police, Community Safety and Enforcement, Housing, the YOS and Children's Social Care.

Information and intelligence sharing has become more common place and in turn this has allowed a far more detailed picture of Hounslow to emerge of where cohorts of young people are, the locations of concerns and gang activity is now tracked and responded to through both existing and newly developed meetings and forums.

The development of the MACE has led to the concept of MACE Contextual Sub-groups. These sub-groups allow for a more focussed view and discussion on a particular cohort and/or location of concern, with practitioners invited from the local area, and who hold local knowledge and expertise, as well as from organisations who may not previously had been invited to the MACE, e.g., local CSV organisations, estate managers, enforcement officers, etc. This allows for agencies involved with the young people in the area or the location to be more focussed on the local resources available to bring about change. Over the last year there has been four subgroups and again these groups have been able to quickly evolve and adapt as need as required.

Although the past year has been positive for the Operational MACE, it has not been without its challenges due to an absence of coordination and administration impacting capacity to collate data that has previously been manually recorded.

There remains a challenge in resolving the membership. This is now being overseen by the AOMG but the level of decision maker attending needs to be addressed if Operational MACE is to be affective in targeting and disrupting under the new format.

Table 1: Numbers of cases open to MACE by month

Month	April 20	May 20	June 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Total
Open Cases	7	7	10	10	10	6	6	5	5	4	5	4	79
New Cases accepted	0	3	0	1	1	1	2	0	1	2	0	3	14
Cases removed	0	0	0	1	4	1	3	0	2	1	1	0	13

Case referrals reflect a lower rate than previous years, especially dipping from September where the cohorts were introduced, and young people were tracked as part of that cohort rather than individually. This has meant that the number of individual cases has reduced. The numbers belonging to cohorts has not been tracked in the year 2020/21.

The previous system of collating data was manually done and a new way of producing data from LCS (children's data system) is being developed that should give a much wider ranging overview for at least part of the coming 2021/22 year and beyond. It is hoped that demographic data can then be included in the analysis of individuals and cohorts on the MACE and careful thought will be given to how the analysis of the data can be used for prevention and targeting purposes. It is hoped that the new system of recording data will be developed by early 2022 and in place to collate data for the second half of 2022/23.

Despite positive steps forward in some areas of its operation, MACE has been in a period of change and flux over the last year. The focus of 2021/22 is to continue to develop the panel in order to demonstrate positive outcomes in disrupting exploitation and serious youth violence and work collaboratively with other risk panels and agencies to share information and intelligence.

Missing from Home, Care and Education

Children Missing from Home Data and Analysis

- The number of children reported missing from home dropped from 108 children in 2019/20 to 99 missing children in 2020/21. This was a drop in 9 children who were reported missing.
- The number of missing episodes also decreased from 243 episodes in 2019/20 to 179 missing episodes in 2020/21. This was a drop of 64 missing episodes.
- The average number of episodes has slightly decreased from 2 missing episodes per child in 2018/19 and 2019/20 to 1.8 missing episode per child in 2020/21.
- The number of children with at least one return interview completed during the year, increased from 55.6% in 2019/20 to 67.7% in 2020/21. This was a slight increase of 12%.

There have been continued improvements in the reporting and recording of young people missing from home during 2020/21. There are fewer young people reported missing from home with fewer missing episodes. It is positive to see a continued increase in the number of return interviews being offered. This is an area that will remain a focus in 2021/22 to ensure all missing young people in Hounslow are offered at least one return interview and have an opportunity to speak about their missing experience.

Children Missing from Care

- The number of children reported missing from care decreased from 76 children in 2019/20 to 72 children in 2020/21. This is a decrease of 4 children.
- The number of Missing from care episodes decreased from 671 missing episodes in 2019/20 to 582 missing episodes in 2020/21. This was a decrease of 89 episodes.
- The average number of episodes only slightly reduced from approximately 9 episodes per child in 2019/20 to 8 episodes per child in 2020/21.
- The number of children with at least one return interview completed during the year, had decreased from 86.8% in 2019/20 to 84.7% in 2020/21 however, the proportion of children that were offered a return interview had increased from 70.8% in 2019/20 to 85.1% in 2020/21. This represents a 15% increase.

Return Home Interviews

When a young person returns from a missing episode the local police conduct a 'Police Prevention Interview'. The purpose of the interview is to establish whether the young person has come to any harm whilst missing. Additionally, the young person is also offered an independent return interview to establish the reasons they have gone missing, if any support is needed and to assess what can be done to prevent future missing occurrences. There are clear processes in Hounslow to ensure all children reported missing from home and care are offered an independent return interview. If they are open to Children's Services, then this could be a duty social worker, or a person identified in the young persons' network. If the case is not open to Children's Services, then the Adolescent Support Team (AST) offer a return home interview for all children missing from home.

Table 1: RI Forms completed between 01 April 2020 and 31 March 2021 for children missing from Home

Number of Episodes Missing from Home	179	
Number of RHI's completed in demographics	91	50.8%
Number of RHI forms completed	179	100%
Number of RI's offered within 72 hours (3 days)	128	71.5%

Table 2: RI Forms completed between 01 April 2020 and 31 March 2021 for children missing from Care

Number of Episodes Missing from Care	582	
Number of RHI's completed in demographics.	377	64.8%
Number of RHI forms completed	381	65.5%
Number of RHI's offered within 72 hours (3 days)	327	85.8%

Table 1 shows 50.8% of children who went missing from home had a return home interview, which is an increase from the previous reporting period 2019/20 when 40.3% had a return home interview. It is positive to see the timeliness of the return home interviews being offered within 72 hours of the young person returning has also increased from 55.9% in 2019/20 to 71.5% in 2019/20. Whilst this is a significant improvement it remains an area of focus in 2021/20 reporting, in order to consider the persistence of return interview offers and also look at the quality of the interviews being completed.

Table 2 shows that although 85.8% of children missing from care were offered a return interview, only 64.8% of children who went missing from care had a return home interview completed. Whilst there is a slight decrease in the number of missing from care interviews being offered since last year when it was 94.1% (2019/20), the uptake and completion of return interviews has improved from when it was 45.8% in 2019/20.The reason for this decrease in return interviews being offered is not known and will require further exploration through auditing and reviewing of cases. However, it is really positive to see the number of children completing return home interviews has improved significantly over this last year.

Quality Assurance

The monthly Missing Scorecard drives all Missing auditing activity. However, due to the complete re-writing of the Missing process, policy and LCS framework, there has been no audit activity this year. There is an audit schedule that will be undertaken by the Exploitation and Vulnerabilities co-ordinator over the next year once the new framework is implemented.

Raising Awareness and Training

Awareness raising has taken place throughout the year, some examples are detailed below:

- There is a process to regularly review the police's missing data and Emergency Duty Teams (EDT) report on a daily basis to monitor Hounslow missing young people and ensure appropriate responses and strategies are put in place to manage this risk. The wider Extra Familial Harm context has expanded significantly and many of our persistently missing young people are tracked and understood as part of the MACE panel or as part of contextual cohorts.
- Further work is being done to ensure that Missing from Education (through the new Virtual College remit) and early missing reports are tracked to offer early intervention to families and contextual analysis of risk for families before a problem escalates to County lines or Serious Youth Violence involvement. This will involve the analysis of this above data in the MACE HUB, due to be implemented by end of October 2021.
- Public Health and partner agencies jointly developed Service User Cards that are available for all young people. These cards were designed to be shared particularly with young people who go missing and refuse a return interview, in order to inform them of some of the key services in Hounslow they can access for support.

Operational Activity for 2021/22

- A new Missing Workflow will be developed to incorporate both missing from home and care processes together.
- CSC recording system will be updated to simplify the recording of Missing Episode information and to generate greater intelligence from Missing episodes making links to other areas of risk and support the Extra Familial Harm risk assessment.

- Replace the current Return Home Interview template with a new 'Intelligence Form' to capture useful data around locations, associates/ peers, behaviours and visual mapping of emerging risks.
- Develop Practice Guidance to support fully embedding the changes into practice.

Children Missing Education

As an impact of Covid-19, the Children Missing Education (CME) Team received an increase in referrals from schools informing of children who had moved out of the UK to attend schools in their home country due to their parents work status. Some families were unable to register their children into new schools because and were either learning at home or accessing online learning from their previous school.

The panel for Special Educational Needs (SEN) pupils had proactively supported young people who arrived in the UK without an Education Health and Care Plan (EHCP). In the last academic year, all Independent Schools in Hounslow had completed their starters and leavers returns and work was being done to improve the content of reporting to include basic information. In the coming year the team would continue to monitor the starters and leavers returns from Independent Schools, to ensure return rates were improved and the information was quality assured.

Elective Home Education

A review of Elective Home Education (EHE) was undertaken at the start of last year which had shown some positive outcomes. It was identified that over 130 families that had not been visited for a number of years and the pandemic had provided the opportunity to undertake socially distance cold calls to families that had not engaged previously. By September all of the families had been engaged with and feedback that they welcomed enquiries about their children. Some families who had previously elected to home educate their children had requested a school place and with support from the Admissions Team children were provided with a school place. It has become standard practice that the EHE team request an education plan from parents on the curriculum coverage for their children for the year ahead. Where there are concerns monitoring and support is increased, and the names of children educated at home were shared with CSC to ensure any safeguarding concerns were identified.

Nationally there had been a significant increase in parental choice to electively home educate and since September 2020, the EHE figures had increased to 189 children mostly as a result of Covid-19 with families reporting that their children would return to school either in April or September 2021. It has become standard practice that the EHE team request an education plan from parents on the curriculum coverage for their children for the year ahead and where there are concerns monitoring and support would be increased.

The ongoing of challenges of inadequate staffing and capacity is impacting ensuring that quality education is being delivered, there is persistent engagement with families who were less willing to receive support and there is communication with Independent education settings informing when children were ''off-rolled''.

As a result of the reported pressures on education services and team, the increase in EHE children the impact on the welfare and safety of young people outcomes of the Serious Youth Violence Review, Adolescent Safeguarding strategy scoping, lines of enquiry identified in Child A Local Safeguarding Child Practice Review outlined in Section 9 of the report the partnership had agreed to adopt Vulnerable Children in Education as a strategic safeguarding priority over the next two years.

Priority 2 – Neglect

Outcome - *Hounslow has a clear strategically driven, multi-agency response to children experiencing neglect, with a well embedded, effective multi-agency strategy and assessment framework leading to a reduction in children and young people experiencing long standing neglect, ensuring families are getting help earlier.*

It has been a challenge to tackle neglect in Hounslow and as a result of significant targeted quality assurance work, the HSCP moved neglect from a core business to a themed priority area for 2019/21 to improve Hounslow's response. The Neglect Strategy was developed and relaunched in January 2020, and so far, its impact has not been seen.

The partnership has seen an increase in neglect cases being considered for learning and two cases have been presented to the Cases Sub-Group which have resulted in Local Child Safeguarding Practice Reviews (LSCPR) being undertaken.

A third multi-agency neglect audit will be undertaken in 2021 to determine what progress has been made.

Achievements in 2020/21:

- Re-established neglect themed Task and Finish group to further embed the use of assessment tools, multi-agency training and challenge of practice and response to neglect.
- Roll out of multi-agency train the trainer programme delivered by multi-agency partners with a focus on QoC Assessment Tool.

Activity for 2021/22:

- Third neglect themed multi-agency audit to be undertaken to assess improvement and impact of strategy and inform strategy revision due in 2022.
- Themed dataset indictors developed linked to strategy objectives, measuring impact and outcomes for children.
- Trial the use of multi-agency chronologies for Child Protection cases.
- Develop and operationalise a Complex Case Panel to address challenging cases including persistent and chronic neglect.
- Support revision and implementation of the digital QoC assessment tool on CSC recording system.

Neglect Task and Finish Group

A second Task and Finish was set up to embed the strategy and to ensure that neglect was being tackled in an effective way. The Neglect Implementation plan was revised, and the actions graded in terms of their priority.

High Priority Actions

1. Agencies to provide assurance, including qualitative narrative and quantitative data on how they are monitoring neglect practice, assessment and use of QoC tool
2. Attendance at neglect training sessions for all operational staff
3. Child Protection (CP) Chairs to assist in supporting implementing the QoC Assessment Tool via CP and Child in Need (CiN) Plans and review them as part of the normal review cycle.

4. Develop a neglect dataset which includes key inductors to monitor the multi-agency response to neglect.

Quality of Care Assessment Tool

The use of the Quality of Care (QoC) assessment tool has improved across the health economy particularly in HRCH who have embedded the tool in supervision. Improvements were made to the tool on CSC recording system to ensure it was easily accessible and triggered as part of the assessment of neglect. The improvements are in the infancy and require further embedding and monitoring to demonstrate impact.

Multi-Agency Chronologies

In 2019 the partnership had recommended the use of multi-agency chronologies to support the assessment of neglect. At the time it was felt that partnership efforts should be focused on the revision of QoC assessment tool and embedding it into practice.

Following the use of multi-agency chronologies by the partnership in its practice reviews their benefit was acknowledged and considered as an essential tool in assessing the cumulative impact of neglect. In January 2021 the partnership agreed that multi-agency chronologies would be piloted as part of the Initial Child Protection Conference process and is due to be launched in September 2021.

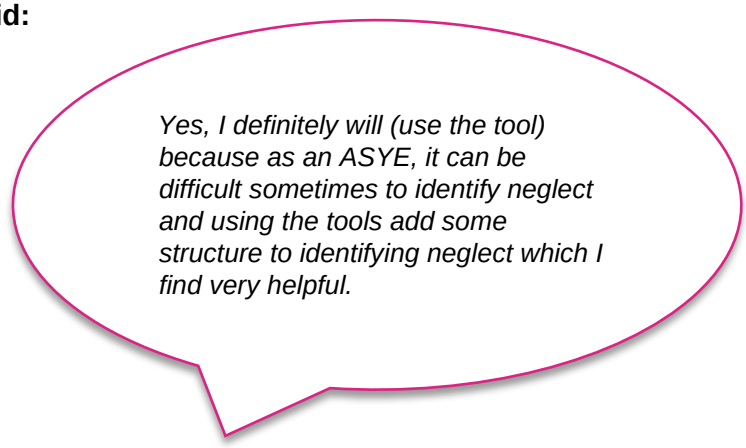
Training for Professionals

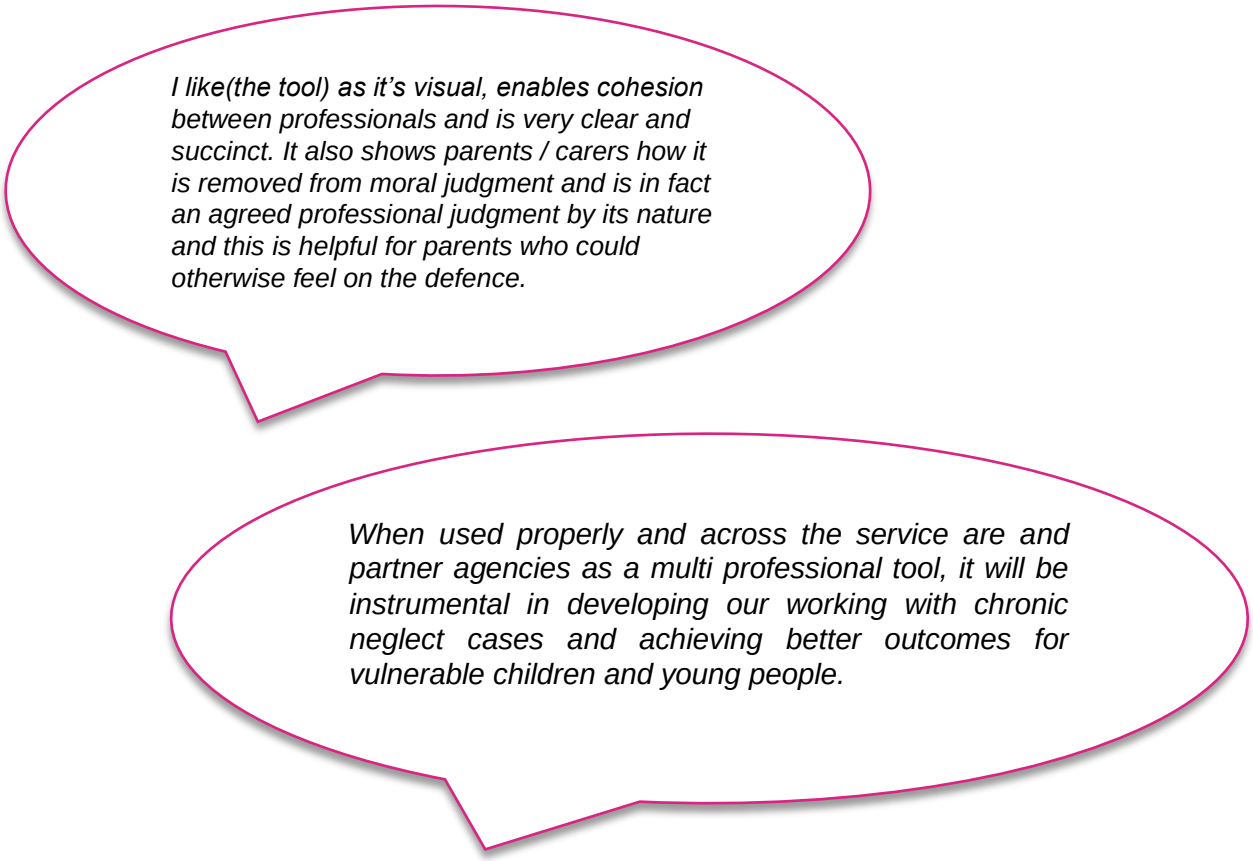
The consistent training of professional on the QoC assessment tool is key to the success of delivering a multi-agency approach to neglect and central to the strategic approach. To mitigate against loss of knowledge, awareness and skill within the system a multi-agency train the trainer programme was developed using professionals working in partner agencies locally. The training team comprised of 5 facilitators from CSC and 5 facilitators from health and as well as delivering training sessions have taken on a champion role within their organisations.

The roll out of the programme was delayed due to Covid and delivery began delivery in October 2020 with approximately 2 workshops per month being offered to professionals. Between October 2020 and April 2021, 171 delegates attended the training session primarily from CSC and health. Given the challenges faced by schools during the pandemic the second tranche of training would be focused on education setting in 2021/22.

Feedback from delegates who attended the training had been positive with many agreeing that there was a need for a strategic multi-agency approach to improve the professional response to neglect.

What professionals said:





Priority 3 - Child Sexual Abuse (focus on interfamilial abuse)

Outcome - *Children suffering from sexual abuse will be identified and responded to effectively, receiving the right support from well trained and well-informed professionals.*

Following the Children's Commissioner's report in 2016, the profile of child sexual abuse has increased once again, and it is expected that local areas strengthen their response and properly equip their workforce. This position is further supported by Ofsted who have developed a Joint Targeted Ares Inspection (JTAI) framework with a deep dive theme specifically exploring child sexual abuse.

In early 2020, the partnership assessed itself against the JTAI framework and national learning which found that Hounslow was not consistently and effectively identifying or responding to the area of risk. Senior leaders across the partnership acknowledged that further work was required and in response, the HSCP significantly increased its focus on the priority in 2020/21.

Achievements in 2020/21:

- Undertaken Child Sexual Abuse themed multi-agency audit.

Activity for 2021/22:

- Outcomes of audit to be addressed in time limited themed Task and Finish group to develop Hounslow Child Sexual Abuse Multi-Agency Strategy and implementation plan in line with JTAI standards.
- Development of bespoke multi-agency training offer to address audit findings to be rolled out from July 2021.

Child Sexual Abuse Multi-Agency Audit Findings

The partnership undertook a Child Sexual Abuse (CSA) audit to baseline Hounslow's position in identifying and responding to children who have experienced or may be at risk of sexual

abuse within their family. Ten children from different families were considered, aged between 6 to 17 years old and who were from different ethnic backgrounds. All of the children were currently or had previously been subject a Child Protection (CP) Plan, Child in Need (CIN) Plan and some were Looked After Children (LAC). The audit benchmarked local practice against the findings of the JTAI and the Children's Commissioners Report.

At the time of the audit there were 231 children on a CP Plan in Hounslow with only 5 children on a CP Plan under the category of sexual abuse and there was an acknowledgement from the partnership that the number of children on CP Plan and section 47 enquires in relation to sexual abuse was low.

The audit recognised strengths and areas of improvements by assessing practice and the effectiveness of systems responding to children at risk of or are being sexually abused and involved frontline practitioners who gave positive feedback that they viewed that the learning identified was to improve practice and not a means of judgement.

The audits were graded using the Ofsted grading of Outstanding, Good, Requires Improvement, or Inadequate and found that only three cases required improvement in safeguarding. Overall, the audit findings were reflective of the national picture in response to the area of risk and identified that Hounslow had the skill and resources to respond well and achieve good outcomes and it was positive that professionals had the right attitude towards addressing the risk. The audit challenged senior leaders to ensure that all practitioners were adequately supported to be more confident and skilled in responding CSA.

Learning identified:

1. Working with children who have or may have been sexually abused is complex work that has an emotional impact on the professionals involved.

2. Professionals need to be able to 'think the unthinkable'.

3. Working with child sex abuse is complex, as children are unlikely to make an outright disclosure of what has happened.

4. Professionals need to be curious about a child's behaviour and identify other indicators that they may be a victim of sexual abuse.

5. Even when a child has made a disclosure it is not always easy for the perpetrator to be successfully prosecuted.

6. Professionals should be clear about the decision made and why no further action is being taken. They should challenge the police/CPS if required.

7. A system which waits for children to tell someone they are being sexually abused cannot be effective. Behaviours, family history and professional observations should be considered within the context that sexual abuse may be happening.

8. The opportunity to build a relationship with a child when a professional has concerns or a 'gut feeling' about sexual abuse is important.

9. The importance of information sharing of the history and current concerns.

10. Therapeutic support can be provided without delay.

11. Professionals must be proactive in seeking the child's views.

12. Professionals should refer to and use the on-line procedures and seek immediate advice from the MASH when they are confronted with a concern about sexual abuse.

13. Specialist advice should be available and sought when working with CSA cases, particularly regarding the perpetrator.

14. Perpetrators of sexual abuse are known to groom children, family members and professionals.

15. When the issue is a child sexually abusing another child in the family, both the alleged child perpetrator and victim need to be considered as children in their own right.

16. Perpetrators can target vulnerable children because they may believe they are less likely to disclose the abuse or be believed if they do.

17. CSA happens in all communities.

18. Strategy meetings need to include all of the professionals involved in the investigation and reviews need to be held until the investigation is complete.

19. The need to consult with GPs particularly prior to or during strategy meetings.

20. COVID-19 had and continues to have an impact on this area of safeguarding.

Recommendations:

1) The HSCP to ensure that there is a focus for the whole system which ensures the development of staff to enable them to work with cases where sexual abuse is an issue.

2) The HSCP to seek assurance that family history is being considered and shared appropriately in cases where there is risk of sexual abuse and that professionals across agencies are requesting and holding meetings to consider complex cases.

3) The HSCP to seek assurance that there are improvements being made in reconvening strategy meetings to consider the results of all child protection investigations, including medicals, ABE interviews, significant updates in a criminal investigation and so on. They should be attended by all the professionals involved and chaired by a professional with suitable experience and objectivity.

A further audit is undertaken in approximately 24 months, to consider progress in this area.

As an immediate outcome of the audit the partnership created a Child Sexual Abuse Learning Briefing aimed at frontline practitioner to begin to immediately strengthen the response to children and young people at risk of CSA. The briefing can be found at HSCP-Child-Sexual-Abuse-Multi-Agency-Learning-Briefing-2021.pdf (hscb.org.uk)

The HSCP has begun to use the learning and recommendations identified in the audit to develop its multi-agency strategy and training offer which will be launched in 2021/22.

The multi-agency training programme has been developed by a multi-agency team of health and CSC professionals, led by the HSCP Training and Development Manager and supported by an experienced train the trainer facilitator who has worked with the Centre of Excellence for CSA. It is envisaged that the team will deliver training once a quarter reaching between 60 and 80 professionals each year

NSPCC PANTS

The commitment to keep the PANTS messages 'alive' in Hounslow and to continue to reach children starting school in future years has been reported in previous annual reports.

Following its success, schools have continued to deliver the campaign independently with direct support from the NSPCC, to ensure the legacy continues and the programme is well embedded into the curriculum as demonstrated through the findings of Annual Education Safeguarding Audit 2020.

The focus of the programme over the last year, has moved to early years settings and the faith community, however progress was impacted by the Covid-19 lockdown. Throughout lockdown, the HSCP has continued to send resources to all partner agencies to support awareness about CSA during a time when children are less visible to professionals.

9) Feltham YOI (FYOI)

The partnership has statutory duties to all young people in FYOI despite very few being from Hounslow. As reported last year, the inspection of the establishment in July 2019 found that standards had slipped further and triggered an Urgent Notification (UN) due to a collapse in the regime.

Of particular concern to the partnership were the findings identified in relation to safety and safeguarding in which the internal governance and structure of the safeguarding team was deemed ineffective and required more robust responses, particularly in relation thresholds and outstanding paperwork.

Since the inspection, the Sub-Group chaired by the Independent Advisor of the partnership has solely focused on robustly monitoring the progress of the UN Recovery Plan. Positively, it has established a good and transparent relationship with the Head of Safety, who is actively engaged with the partnership and providing regular assurance reports supported by analysed data and is responsive and proactive in addressing partnership concerns. The processes between the LADO and the Safety Team have improved, thresholds are applied properly, and the level of referrals has reduced significantly.

At the end of 2019, a further process of independent scrutiny was established between the HSCP and YCS. It was agreed that they would conduct joint unannounced visit to quality assure systems, processes and recording and consult with young people and staff directly. Two unannounced visits took place in January and February prior to restrictions imposed due to Covid-19 and it has not been possible to resume the programme due to ongoing restrictions.

Progress since the last inspection is evident and there is a commitment by the leadership team to continue make incremental sustainable change. The re-inspection of the establishment was delayed due to Covid-19 however a number of scrutiny visits and activities have taken place which have provided assurance that progress against all areas of the UN and in particular safeguarding has continued. FYOI said of the support offered

> ''*The - HSCP and the Local Authority worked through this period of time with Feltham and the new Head of Safeguarding to support the Establishment in improving all aspects of Safeguarding Children at Feltham. There has been a good working relationship revived between Feltham and the HSCP and the Local Authority with a good level of external scrutiny that ensures we maintain our positive journey at Feltham since the UN.*''

Covid-19

During Covid-19, the regime for young people was significantly restricted as it was for those in the community in order to limit the spread of the virus. Despite the restrictions the establishment worked hard to ensure that young people were able to form small ‘’bubbles’’ and were out of their rooms for approximately 3 hours a day, and they continued to have access to healthcare, education on their units and virtual visits with their family. This was confirmed by HMIP who undertook a Scrutiny Visit across two YOI sites which included FYOI. The visit highlighted the positive work undertaken by the establishments to keep young people safe during Covid-19.

Minimising and Managing Physical Restraint (MMPR) Annual Report 2019/20

As required in WTSC it is a statutory obligation that a YOI in a local area produced an annual report on Control and Restraint/ Use of Force which is submitted to the Local Safeguarding Children Partnership for scrutiny before being shared with Youth Custody Service (YCS).

The report highlighted that since the UN there had been a significant reduction in the use of MMPR and that there were now robust processes in place. The approach to use of force was positive and the downward trajectory was being closely monitored to recognise changes and patterns and maintain progress.

The full report is available on the HSCP website at Annual Reports & Business Plans - HSCP (hscb.org.uk)

Child Protection (CP) Medicals

In addition to the focus on progress of the UN, over the last year, the partnership, FYOI, the LADO and Hounslow Clinical Commissioning Group (CCG) have been working to ensure that young people have access regular and timely Child Protection (CP) medicals. There has still not yet been a resolution nationally about the commissioning arrangements for CP medicals in secure estates, however, to prioritise the best interests of young people, Hounslow CCG, Hounslow Richmond Community Healthcare (HRCH) and FYOI have worked together to develop a local protocol to ensure that those requiring medical examination by Community Paediatricians, receive an assessment in a timely way, in the setting that is most appropriate to meet their needs.

As an impact of the ongoing absence of national clarity about expectations of CP medicals, there had been some challenges in the understanding of local process due to both commissioning and statutory responsibilities over the last year. As a result, the local protocol was refined and amended to ensure clarity and statutory obligations are met.

LADO

The relationship between FYOI and the LADO has continued to be strengthened as recognised by Ofsted during their Focused Visit, by HMIP and by the YCS. Additional funding was received from London Councils on behalf of all Directors for Children’s Services across London for a part time LADO to meet the growing demand from FYOI and a dedicated Business Support Officer was appointed to support the with administrative work.

New Terms of Reference (ToR) were created to ensure that robust measures were in place which set expectations of the LADO in the establishment. A consultation form was developed to record discussions regarding cases that did not meet a formal LADO referral to ensure robust

oversight and learning points identified. Further refresher training has been offered to staff to ensure that they are aware of the LADO role and responsibilities.

The LADO has continued to undertake monthly audits for cases that did not meet the threshold for a LADO investigation and/or have been subject to an internal investigation and the Designated Nurse and the HSCP Business Manager had joined the panel to act as critical friends and contribute further multi-agency oversight.

Resettlement

The safeguarding processes and links in resettlement activity have improved with the appointment of a new Head of Service with clear objectives for the service to consider when working with young people reintegrating back into their communities. Improved relationships with external agencies and young people's local areas have ensured that there were more successful and safer transitions out of the secure estate.

Despite the improvements in consideration and planning of the safeguarding needs of a young person, securing appropriate and timely accommodation for young people prior to their release remained an ongoing concern. For a young person within a custodial setting, not knowing where they will be placed upon release creates a significant amount of stress and fear and there is evidence locally that shows a link between an increase in violent incidents or behaviour in the days prior to a release when their plan is uncertain. There are examples of young people returning back to secure establishments quickly upon release if their placement is not considered or appropriate for them to remain in the community. The Sub-Group will continue to support FYOI on challenging local areas to provide young people with accommodation in sufficient time prior to their release.

Good Order or Discipline (GOoD) (Rule 49) Audit 2020

The HSCP has proactively undertaken audits in FYOI for a number of years however the audit programme was paused in 2019 because of the UN and the focus on delivering the actions and recommendations outlined in the improvement plan. The GOoD audit was planned for April 2020 but was delayed because of Covid-19 and was undertaken in October 2020.

The audit found that the processes used for managing the separation of young people were strong, in line with expectations and there was good oversight from senior leaders. The creation of Falcon Unit, a dedicated unit that sits within the safeguarding function has expedited the improvements since the UN. Young people who need to be separated for safety reasons and those who are self-isolating through choice, are now clearly differentiated into two cohorts and managed through different pathways and interventions, which is more appropriate.

Incidents of separation reviewed as part of the audit, with exception of one which was challenged by the Governor, were as a result of violence and the risk they posed to themselves or others as a result of their behaviour towards their peers, which evidences that the process is viewed as a risk assessment management tool and not to manage behaviour or punishment. Young people were on average separated for much shorter period of time and the interventions and targets set for them are better tailored to their individual needs, although further work could be done to include the people that know the young person best.

Falcon unit is not a normal home unit and the staff are able to provide one to one support to the young people as there is higher staff to young person ratio. The practice and model of unit demonstrated that it was beginning to have impact and was something that young people value. With ongoing support from Falcon staff, the principles of work could be expanded and adopted

by the officers on other units to support building relationships and assisting in de-escalating or preventing incidents.

The audit identified that further work was needed to ensure young people have a clear voice and footprint in their separation reviews, as well as in their daily lives across the establishment. They were clear that they value consistent positive relationships that they have with staff on Falcon Unit, and they believe this is why they are separated for a shorter amount of time, and overall, have less episodes.

Feedback from Young People

As part of the audit, discussions were held with four young people who had been separated during the audit period. As an outcome of the discussions each of the young people identified recommendations for improvement which they would make to the establishment.

Recommendations from young people

1. All officers should do more to allow young people to be out of their room more often and help them build a community on their unit.
2. All officers to show more interest in young people.
3. For all units to have a clear daily structure and routine.
4. For there to be respectful relationships between officers and young people like they experience on Falcon Unit.
5. More focus on promoting restorative behaviours when a young person returns from separation.

Response from FYOI to the Audit Findings

‘*’HMYOI Feltham is one of the most complex and diverse custodial establishments in the country and both the staff and young people and young adult population reflect the great cultural diversity across our catchment area. We are committed to uphold the highest standards in promoting and practicing equality in everything that we do.*

- *Feltham was pleased that the audit found the use of Rule49 lawful with robust oversight and assurance in place and this continues to be in place and is part of the structure of the process.*
- *Feltham accepts that some of the documentation and rationale around Separation was not always clearly communicated but the JAPAN model has been implemented and will continue. This gives a clearer recording of justification of separation.*
- *Actions plans are in place for all individuals and it is positive that there is improvement from the previous audit.*
- *The shorter periods of separation are also recorded through the recorded data at Feltham and the YCS.*
- *There is a clear difference between Rule49 and self-separation and this continues with work with staff at Feltham.*
- *The post closure interview has ensured that our managers on the unit have awareness of the process and children.*
- *There has been inconsistent attendance at Separation meetings but this has improved through the months through the audit. In the last 6 months there has been some good attendance and this improves over the months as we introduce formulations to the Rule49 reviews.*
- *Education do see the children, but further work needs to be completed to ensure this is documented and consistent.*

- *There are improvements with the impact on the children and their focus on Falcon. The children are getting a consistent regime across Feltham A so children no longer want to be separated just for a regime.*
- *Adjudications are being held on Falcon and there is now a process where children have a restorative option to improve their behaviour.*
- *There is a good process and clarity over the role of Falcon and this is a good improvement from previous HMIP.*
- *Equalities is difficult to manage at Feltham currently due to the disparity in the population.*

10) Learning and Improvement

Case Reviews and Learning

In the last year, four serious incidents have been notified to the DfE and Rapid Reviews (RR) have been held as per statutory guidance, two of which progressed to Local Safeguarding Child Practice Reviews (LSCPR) with themes of chronic long-term neglect and absence from or inconsistent engagement with education whilst known to statutory agencies. Findings and proposed recommendations from one of the reviews which is near completion identified areas of improvement which link to the multi-agency Neglect Strategy and have already been addressed by parallel workstreams.

LSCPR – Family X

Theme of review – Long-term neglect

The review explored support and services working with the family from January 2013 - April 2020. The review sought to understand and evaluate responses in the following key areas of learning identified through the Rapid Review:

- Voice of the child/children
- Effectiveness of communication and collaboration regarding Child Protection medicals
- Understanding and/or awareness of the indicators of neglect / abuse missed by multi-agency safeguarding system on a number of occasions
- Understanding and/or awareness by all agencies of multi-agency Child Protection Plans
- Action taken by the multi-agency in response to missed health appointments and parents' failure to progress the health issues for all children
- Failure to meet threshold for therapeutic support
- Decision making within the Child Protection Case Conference process
- Assessment of safety / controlling behaviours by mother's partner
- Disguised compliance and professional curiosity
- Effectiveness of interventions offered by all services throughout the timeline of the review
- Effectiveness of professional scrutiny and challenge
- Opportunity for children to feel safe to make disclosures
- Extent to which efforts were made to engage the children's respective fathers in the Child Protection Plans

The review is due to be published in September 2021.

LSCPR – Child A

Theme of review – Long-term neglect, absence from education

The review began in September 2020 and will explore the support and services working with the family from January 2011 – August 2020 and seeks to understand and evaluate responses key areas of learning identified through the Rapid Review and recommendations made by the National Panel:

- The focus on the child in all assessments and understanding how she became less visible to professionals. ***(Requested by National Panel)***
- What opportunities were created for the child to make disclosures.
- The assessment and consideration of undiagnosed parental mental health impacting parenting and ability to make and sustain positive changes.
- The effectiveness of decision making and assessment of risk, outcomes and impact within the Child Protection Case Conferences and multi-agency safeguarding meetings.
- Professional understanding of the reasons for Elective Home Education within the timeline of the child's life and how well it was explored and understood. ***(Requested by National Panel)***
- The understanding and consideration by all agencies of the impact of Elective Home Education on the child and its consideration in assessments of risk. ***(Requested by National Panel)***
- Professionals understanding and/or awareness of the indicators of neglect / abuse missed by multi-agency safeguarding system.
- De-escalation as a means of engagement and compliance when the family disengaged
- The effectiveness of interventions offered by all services throughout the timeline of the review
- The effectiveness of professional scrutiny and challenge across the network
- How well information was shared across the system and the effectiveness of the pathways to feedback to referrers
- The effectiveness of the role of GP, School Nursing Services and CAMHS in the child's life. ***(Requested by National Panel)***

The review is due to be published in early 2022.

Summary of LSCPRs

As outlined in section 8 of the report Neglect has been a themed priority for the HSCP who launched its two-year multi-agency Neglect Strategy 2020-22 in January. The strategy focuses on the importance of consistent joint multi-agency assessments and using the Quality of Care Assessment tool, being at the centre of a robust response of neglect.

Although the timeline of learning identified in the reviews, in part precede the targeted work undertaken by the HSCP over the last two years, the analysis of the cases has identified clear areas of improvement of the multi-agency system working with the family to assess and respond to the indicators of neglect and the use of step down as means of managing hard to engage families effectively and consistently.

The learning from each of the reviews will be collated along with the objectives of the strategy and outcomes of the task and finish group to form a basis of the lines of enquiry for the third multi-agency neglect audit.

Learning Reviews

In the last year, two of the serious incidents notified to the DfE and National Panel did not result in decisions to conduct LSCPRs. In each case the rationale and decision making were agreed by the National Panel. Both of the cases were of murder/suicide of families unknown to services

and the Rapid Reviews did not identify learning that raised safeguarding concerns or would prevent further incidents of a similar nature and both cases were determined tragic incidents which could not be prevented.

Domestic Abuse Systemic Review

As reported last year, the HSCP commissioned a wider multi-agency systemic review using the learning from the local case reviews, reviewing the impact of the actions identified in response to the 2017 JTAI recommendations and more recently the learning generated by Ofsted, published in January 2020 *'Domestic Abuse: Keeping the Conversation Going'* to determine whether improvements were effectively embedded and having impact to achieve good outcomes and that the system continues to evolve.

The partnership had initially planned to host a face-to-face event for the Domestic Abuse (DA) Review which was hampered by Covid-19. Instead, virtual multi-agency group sessions were held with good engagement from professionals. Schools were not represented at the sessions which was a gap.

Review themes:

- perception of risk
- children's voice and lived experience
- considering the cultural context
- understanding of thresholds
- effectiveness of information sharing.

Review findings:

Professionals spoke about their experiences in DA cases and the evidence received was anecdotal which was viewed as a starting point for the partnership to further consider the response to DA. The review found that there was a need for collaborative working across agencies and a joint responsibility in safeguarding meetings and plan for children who were exposed to DA. There were still improvements to be made and also positives to build on. The review that particular focus was needed on:

- Those who work with adults need to 'Think Family' in DA cases.
- Improve confidence and an understanding of the monthly MARAC to improve and increase referrals, attendance, and information sharing.
- Professionals were confident that routine enquiry in health settings had supported identifying DA and this was both a national and local picture.
- Professionals who work with families need to have specialist DA training.
- Improvements to be made in seeing the risk to the child.
- Engagement with the perpetrating parent who may still live with the child is important.
- Ensuring the children's voice and their lived experienced is understood
- Consider the adult relationships in the family through the eyes of the child.
- Awareness of how to access the services in place to support children and their impact.
- Considering the cultural context
- Appropriate use of interpreters
- Understanding of thresholds
- Referrals need to capture the history, accumulative impact on the child and the likelihood of ongoing or future harm.
- Effectiveness of information sharing

The final report and recommendations were presented to the partnership Board in June 2021 and will be incorporated into appropriate workstreams and the work to implement the new Domestic Violence Bill 2020.

Case Learning Discussions

The Cases Sub-Group has actively increased the number of cases it discusses which do not meet the threshold for practice reviews but offer valuable learning by retrospectively exploring what went well and where improvements could have been made which we can learn from to strengthen future practice. Five key themes were identified as impacting the progress of operational practice. The themes are also inline with learning identified in larger learning reviews and case audits.

Themes identified were:

- Understanding of differing thresholds
- Appropriate and timely professional challenge
- Consideration of and resolution to differing professional views
- Differing perception of risk
- Clarity and rationale for decision making
- Appropriate and timely professional escalation

In response the partnership prioritised the revision of the multi-agency Threshold Guidance and Assessment Protocol which was ratified by the partnership in April 2021 and a revision to the multi-agency professional Escalation Policy which was ratified by the partnership in January 2021. In the coming year the partnership will work to ensure that both documents are well embedded into practice and develop systems to track their impact.

11) Effectiveness, Assurance & Performance

Effectiveness of the Safeguarding System

Outcome - *There is a solid, strong and responsive multi-agency safeguarding system in place which fulfils its responsibilities to children and families needing support from early help services to children and young people needing to be looked after by the Local Authority.*

Assurance and Performance

The HSCP aims to undertake as a minimum of one deep dive themed multi-agency audit per year, linked to either its priorities or emerging concerns. The partnership is increasingly trying to be more intelligence led in its responses and using creative ways in which it can assure itself about practice and identify areas of improvement by using existing information internally generated by agencies such as dip samples, learning reviews, data and quality assurance activity.

As outlined in section 8 the partnership undertook a comprehensive multi-agency audit of 10 cases focusing on Child Sexual Abuse. Audit work was undertaken in FYOI scrutinising the use of isolation and the annual safeguarding audit of schools was postponed due to the pandemic. The 2019 audit was left open for schools to complete or update, and the normal cycle will resume in January 2022.

Quality Assurance and learning activity planned for 2021/22:

- Strategic Safeguarding Compliance Audit (previously Section 11)
- Annual Education Safeguarding Audit 2022 (rolled out in Jan 2022)
- Neglect Multi-Agency Audit
- FYOI Control and Restraint Audit
- JTAI framework self-assessment against standard criteria and current themes.

Police Protection Audit 2020

Following the last Ofsted Children Social Care (CSC) Focus Visit and a challenge made to the partnership by the previous, Detective Superintendent, the Police and CSC undertook a joint audit to specifically explore the use of Police Protection in practice. The review found that the law in relation to Police Protection is interpreted and applied proportionately in practice when involving younger children.

Overall, the review found that communication between Police and CSC was generally good. There was some evidence of difference in recording of information between the Police and CSC, but it had not had an impact on the overall decision or impact on child/young person involved. The review found that, although there are areas of learning that needs to be promoted, the systems were in place to support this and agencies were already working on improving practice in this area. The review did not identify any new areas of learning that had not yet been identified and instead highlighted the need to ensure that changes to practice were embedded and consistent across agencies.

Recommendations:

1) Consideration is given to complete an information pack for young people who are at risk of family breakdown and by virtue more at risk of needing to be accommodated. Providing the Police with a standard information pack could support and inform their decision in relation to the need for Police Protection in these type of situations with adolescents.

2) Discussion with EDT out of hours is essential prior to initiating Police Protection for adolescents to support a discussion about accommodation under Sec 20.

3) Embedding the newly launched Multi-agency strategy meeting practice standards to ensure that a follow up strategy meeting takes place and is recorded following Police Protection.

4) Strategy meeting to be attended by manager with right level of decision-making authority and expertise, for all agencies.

Progress Against Assurance Activity from 2019/20

Effectiveness of Multi-Agency Safeguarding Meetings Audit 2019

Throughout 2018/19, following challenge at partnership meetings, quality assurance activity and feedback from Ofsted during the ILACS inspection in 2018, the partnership became concerned about the effectiveness of operational multi-agency safeguarding meetings, including the consistency of multi-agency participation which could impact collective decision making and compliance with safeguarding procedures.

In response the partnership commissioned an independent deep dive audit which was undertaken between May and September 2019. Fourteen recommendations in total were made and the report and its findings were agreed by the partnership in January 2020.

A task and finish group reporting to the Safeguarding Effectiveness Sub-Group was set up to address the recommendations and met between January and September 2020. Despite the challenges posed by Covid-19 and re-deployment of some staff, the group had active participation and consistent attendance by multi-agency representatives and significant progress was made against priority areas of the action plan, further demonstrating the commitment by all agencies to quickly respond to the findings.

Actions were identified to respond to the fourteen recommendation. Approximately half of the recommendations and subsequent actions were single agency focused and the task and finish group agreed to prioritise addressing the attendance at multi-agency meetings and the revision of the Child Protection Case Conference (CPCC) model both of which required the biggest multi-agency participation.

Significant work was undertaken to improve attendance by partners at multi-agency meetings, in particular strategy meetings. Improvements in the attendance at meetings was supported by the transition to a fully virtual model (expedited by Covid-19), the creation of a SPOC list for all health providers who could be contacted in time critical circumstances and the development of supporting multi-agency practice guidance. Dip sample auditing, completed by CSC, looking at health attendance at strategy meetings, showed that 88% of school nurses and 95% of health visitors had been present. Of the cases where health was not represented, the audit identified that this was due to exceptional circumstances. Whilst good progress was made to improve health attendance at strategy meetings, further work was required to ensure that where possible and in particular in complex cases, strategy meetings include all agencies working with the child and family, such as specialist health services, education providers and that specialist agencies such as the Youth Offending Service, were included to ensure that risk is properly identified and fully considered. Improvements in this area were also found in the CSA and Police Protection audits. To ensure that initial improvements are maintained, and further progress is made, partner agencies and the HSCP have included the review of attendance at strategy meetings and participation in CPCC as part of their core monitoring and quality assurance activities and regularly report findings to the partnership via the appropriate sub-group.

The revised CPCC model, revised report template and supporting multi-agency guidance was discussed and endorsed by the partnership in June 2020 and went live in July 2020. Feedback and discussion by services represented at the task and finish group found that the new approach had been implemented and embedded well, and that professionals were clear about the new requirements which would begin to better support the identification of risk and subsequent planning. The Safeguarding Effectiveness Sub-Group commissioned a report about the impact of the revised CPCC model from the Review and Quality Assurance Manager to be submitted to its meeting in January 2020 which was delayed due to staff absence. The previous post holder left the Local Authority in May 2021 and the report will be submitted by the new post holder in autumn 2021.

The recommendations relating to consistency of SMART planning, quality and consistency of recording the rationale of Section 47 investigations, including the voice of the child and improving tracking and monitoring throughout various parts of the system made less progress and were transferred into CSC departmental improvement plans.

Voice of Practitioners on the Front Line

It is the commitment of the partnership that the view of front-line practitioners is heard and considered when developing safeguarding practice, wherever possible, providing a clear line of

sight from strategic planning to front line delivery. The Safeguarding Effectiveness Framework aims to maximise opportunities through case reviews, audits, learning cycles and utilise established practitioner and professional engagement forums. Over the last year as demonstrated throughout the report, practitioner consultation and feedback has been actively sought and considered when progressing the Business Plan and it has been central in shaping the strategic outcomes and programmes of work such as:

- Child Sexual Abuse Audit
- Domestic Abuse Systemic Review
- Neglect Task and Finish Group
- Rapid Reviews
- Local Safeguarding Practice Reviews

12) Private Fostering

As referenced in **section 5** the partnership has not received any information in relation to Private Fostering in Hounslow. This is a significant gap in comparison to previous years and has been prioritised to be addressed urgently in 2021/22.

13) Voice of the Child

The HSCP has made some improvements in seeking the views of families and children when undertaking learning activity, as outlined in the Safeguarding Effectiveness Framework. Opportunities have been offered to young people and their families during all of the partnerships work programme over the last year, although their engagement and a willingness to contribute in some of the activities, particularly when exploring some aspects of safeguarding adolescents has been more challenging.

Mental Health Life Skills for Young People in the Care System

There have been ongoing discussions about the representation of the voice of children and young people at the partnership. As part of the discussions with the Participation Service the issue of unmet mental health support for this group of young people was identified once again as it had been previously by young people themselves who were invited to speak to Board members.

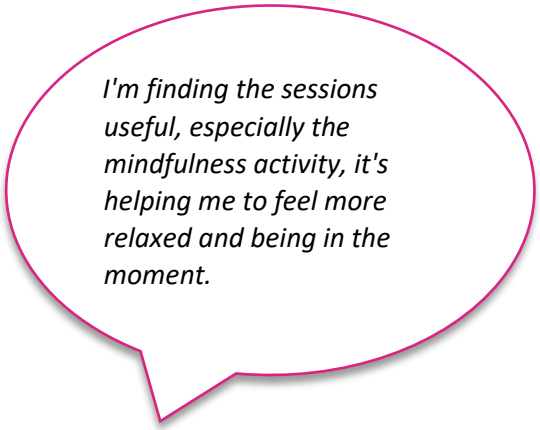
After consultation with young people, they were clear about their feelings of anxiety and needing guidance about how to promote their own wellbeing and mental health rather than therapy.

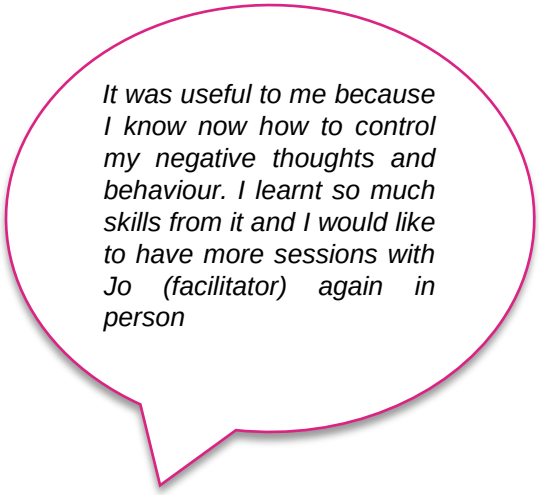
The HSCP commissioned an expert in yoga and meditation to co-develop an 8-week course programme with the Participation Service to support them with:

- Developing resilience to stress, uncertainty, and conflict knowing how to look after themselves based on who they are and what they need to be well and happy.
- Know their triggers and how to manage them and understand why this it is important for building successful relationships.
- Understand that how they think creates how they feel empowering them to can change what and how they think, they can change how you feel.
- Learn how to view situations in a way that empowers and builds self-esteem, becoming their own best inner coach rather than critic.
- Use core mindfulness techniques to help stay strong and resourceful.
- Trust themselves and be able to ask for help when they need it.

The course focused on a different mental health life skill each week and ran for 8 weeks from January to March, followed by a 6 week mindfulness course from April – June. In total 16 young people took part with 7 young people completing the programme. Participants were given a mindfulness book at the end of the course so they could continue to develop their skills.

What young people said:





The HSCP will need to continue to prioritise improving its engagement and find more creative ways to include children and families in shaping the strategic decision making in the Borough, however, it is recognised that it should be in a considered and meaningful way to avoid it being an exercise to tick a box or attempt to fulfil expectations that is not solely in the partnerships remit to resolve.

The partnership has had very limited information from partner agencies in relation to service user feedback. As part of the annual report review cycle the partnership will request a supplementary paper which collates and analyses feedback and service delivery from a user point of view. The information will be triangulated against intelligence and areas of work already identified by the partnership and used to refocus priorities as needed.

14) Conclusion

Partnership efforts have predominantly been focused on the themed priorities of safeguarding adolescents, neglect and child sexual abuse and refocusing on seeking assurance about how well the core safeguarding system is operating and what impact it is having in making a difference to children's and families.

The priorities of the HSCP through its 2019/21 business plan are some of the most complex and challenging areas of safeguarding, with no single response having been determined as wholly effective, and the attention from the partnership has been on properly understanding the local position, what is working well and identifying where gaps and improvements are needed, to provide a foundation to develop approaches that work best for Hounslow.

As reported last year the partnership successfully improved its focus and activity in relation to child sexual abuse, which as outlined in the report and has put it in a strong position to develop a localised multi-agency strategy supported a bespoke training offer over the coming year.

The HSCP continues to be challenged by the lack of analysed data and single agency safeguarding audits and outcomes of quality assurance activity which is shared with it by its partner agencies and was again recognised as an area of weakness for the partnership. The issue has been consistently highlighted in previous annual reports and there is a recognition that good data is integral to any safeguarding partnership fulfilling its assurance, challenge and oversight responsibilities, as well as contributing to operating from an evidence-based position, to support targeted responses across the safeguarding system. In 2021 the issue was escalated to the HSCP Executive Board for discussion and resolution as it was recognised that there is limited analytical capacity, despite a significant amount of data produced across all organisations in Hounslow.

As the report demonstrates, the partnership and its member agencies have been working hard to deliver against the Business Plan and associated work plans and have continued to coordinate and seek assurance that arrangements are effective, and that children and young people are safeguarded despite the ongoing pressure posed by the pandemic.

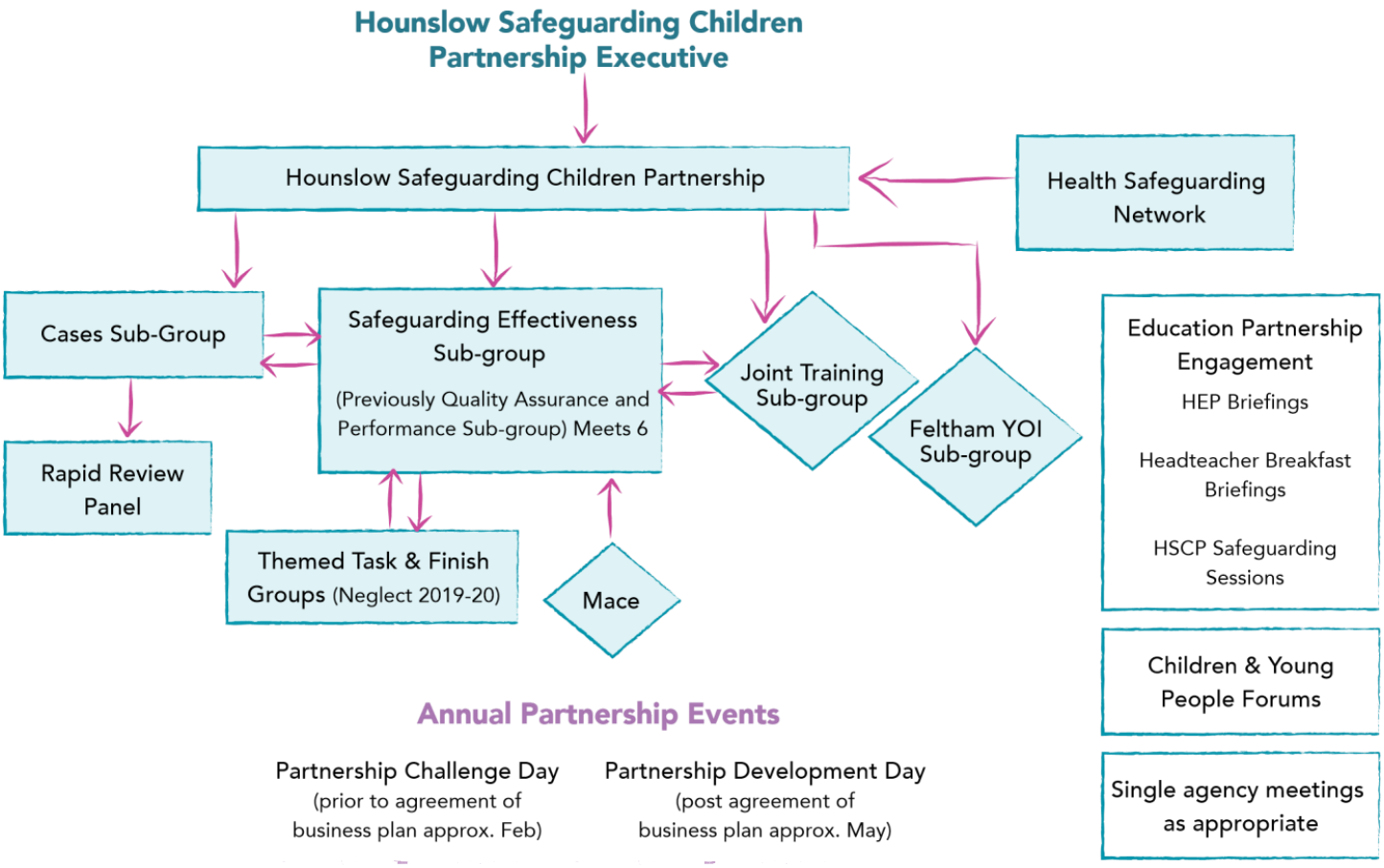
Progress has been made across the business plan during the last two years, including improvements to the core business responsibilities and oversight. The partnership has continued to strengthen its learning function which is being translated quickly into training and development activity.

Priorities for 2021/23

As outlined, a significant amount of work has been achieved against the priorities identified by the partnership in 2019. Alongside delivering its core business function and responding to emerging need, it is recommended that two of the previous themed priorities should remain in place for a further year as well as adopting a further four priorities which have been identified through the HSCPs quality assurance, learning and challenge functions.

P1 (Ongoing) – Neglect *(retain until 2022 for multi-agency audit to be undertaken)*
P2 (Ongoing) – Child Sexual Abuse *(retain until 2022 for strategy to be developed and initial training programme delivered)*
P3 (New) – Vulnerable children in education (identified through systemic and practice reviews)
P4 (New) – Children with disabilities and SEND (identified through partnership member consultation)

Appendix A – HSCP Structure



(the structure links with other strategic boards and appropriate subgroups)

Appendix B - HSCP Board Membership and Attendance April 2020 - March 2021

Role	Representing	Partnership Role	Attendance	Extraordinary Meeting re Covid-19
Independent Advisor	Hounslow Safeguarding Children Partnership	-	5/5	1/1
Business Manager	Hounslow Safeguarding Children Partnership	Advisor	5/5	1/1
Training and Development Manager	Hounslow Safeguarding Children Partnership	Advisor	3/5	-
Councillor	LB Hounslow	Lead Cabinet Member for Education and Children's Services	2/5	-
Children's Services (Statutory Safeguarding Partner)				
Executive Director	Children's and Adults Services	Executive and Partnership Member	4/5	1/1
Children's Social Care (Statutory Safeguarding Partner)				
Interim Assistant Director	Children's Safeguarding and Specialist Services	Executive and Partnership Member	4/5	1/1
Head of Safeguarding & Quality Assurance	Children's Safeguarding and Specialist Services	Partnership Member	5/5	1/1
Head of Adolescent Services	Children's Safeguarding and Specialist Services	Partnership Member	1/5	-
Health (Statutory Safeguarding Partner)				
Associate Director for Safeguarding Children	Hounslow CCG	Executive and Partnership Member	1/5	1/1
Designated Doctor for Safeguarding Children	Hounslow CCG	Advisor	4/5	1/1
Designated Nurse for Safeguarding Children	Hounslow CCG	Advisor	4/5	1/1
Consultant Midwife for Public Health & Safeguarding	Chelsea & Westminster Hospital	Partnership Member	5/5	1/1

Director of Nursing	Hounslow Richmond Community Health (HRCH)	Partnership Member	1/5	-
Named Nurse for Safeguarding Children	Hounslow Richmond Community Health (HRCH)	Partnership Member	5/5	1/1
Director of Safeguarding Children & Adults	West London NHS Trust	Partnership Member	3/5	1/1
Named Nurse for Safeguarding Children	West London NHS Trust	Partnership Member	2/5	1/1
Service Manager	Arc / Hype Drug and alcohol Service	Partnership Member	3/5	-
Borough Commander	London Ambulance Service	Partnership Member	0/5	-
Police (Statutory Safeguarding Partner)				
Detective Superintendent	West Area BCU	Executive and Partnership Member	4/5	-
T/Detective Chief Inspector	West Area BCU	Partnership Member	1/5	-
Local Authority Education (Relevant Agency)				
Interim Assistant Director for Special Educational Needs and Disability	Education	Partnership Member	2/5	1/1
Interim Assistant Director Education & Skills	Education	Partnership Member	5/5	0/1
LB Hounslow (Relevant Agency)				
Head of Community Safety	Community Safety Team	Partnership Member	2/5	1/1
Assistant Director Homelessness, Independence and Preventative Services	Housing	Partnership Member	2/5	-
Children's Commissioning Manager	Public Health	Partnership Member	2/5	-
Education (Relevant Agency)				
Nominated Representative	Alternative Provision and Special Schools	Partnership Member	4/5	-
Nominated Representative	West Thames College	Partnership Member	3/5	-
Nominated Representative	Secondary Schools	Partnership Member	0/5	-

Nominated Representative	Primary Schools	Partnership Member	2/5	-
Invited Representative	Independent Schools	Partnership Member	1/5	-
Secure Estate and Probation Service (Relevant Agency)				
Head of Safeguards	Feltham Young Offenders Institute	Partnership Member	5/5	1/1
Head of Service	Hounslow, Kingston and Richmond, National Probation Service	Partnership Member	2/5	-
Partnership and Contracts Manager	Community Rehabilitation Company	Partnership Member	0/5	-
Relevant Agencies				
Nominated Representative	Voluntary Sector (Homestart)	Partnership Member	0/5	-
Service Manager	CAFACSS	Partnership Member	2/5	-

Appendix C – HSCP Budget 2020/21

Contributors	Hounslow 20/21
Local Authority CSC	£125,446.00
Local Authority – Other Departments	£4,000.00 (Early Years)
CCG	£30,000.00
MOPAC	£5000.00
Fire Brigade	£500.00
Probation	£1000.00
NHS Trusts	£0
Training income	£0
Total Budget	£165,946.00

HSCP Expenditure 2020/21	
Expense	**Spend**
Salaries	£150, 854.22
Chair	£18,125.00
Training	£20,500.00
Quality Assurance and Review Activity	£14,762.00
Strategy Development	£5637.00
Website Hosting	£1002.00
TASP Membership	£775.00
Total spend	£211,955.22

Appendix D – Glossary of Terms

CCE – Child Criminal Exploitation

CCG - Clinical Commissioning Group

CDOP - Child Death Overview Panel

CFAN - Child and Family Assessment Notifications

CG - Core Group

CIN – Child in Need

CLA – Children Looked After

CME - Children Missing Education

CP – Child Protection

CPCC – Child Protection Case Conference

CPP – Child Protection Plan

CSA – Child Sexual Abuse

CSE – Child Sexual Exploitation

CSP – Community Safety Partnership

CSPB – Community Safety Partnership Board

DA - Domestic Abuse

EHCP - Education Health and Care Plan

FYOI – Feltham Young Offenders Institute

HRCH - Hounslow Richmond Community Healthcare

HSAB – Hounslow Safeguarding Adults Board

HSCB - Hounslow Children's Safeguarding Board

HSCP - Hounslow Safeguarding Children's Partnership

ICPC – Initial Child Protection Conference

ILACS - Inspection of Local Authority Children's Services

JTAI - Joint Targeted Area Inspection

LAC - Looked After Children

LADO – Local Authority Designate Officer

MACE - Multi-Agency Criminal Exploitation Panel

MASA - Multi-Agency Safeguarding Arrangements

MASH - Multi-Agency Safeguarding Hub

QA - Quality Assurance

QoC – Quality of Care

RR - Rapid Reviews

SCR - Serious Case Reviews

SEND - Special Educational Needs and Disability

SPOC – Single Point of Contact

SYV - Serious Youth Violence

UN - Urgent Notification