Hounslow Safeguarding Children Partnership Meeting
Monday 27th September 2021
2.30pm – 5.00pm
Virtually, via MS Teams

Attendees		
Name	**Agency**	**Designation**
Hannah Miller	Hounslow Safeguarding Children's Partnership	Independent Advisor
Councillor Tom Bruce	Education and Children's Services	Councillor
Jo Leader	Hounslow Safeguarding Children's Partnership	Service Manager
Janet Johnson	Hounslow Safeguarding Children's Partnership	Learning & Development Manager
Martin Forshaw	London Borough of Hounslow	Interim Assistant Director – Children's Safeguarding & Specialist Services
Amanda Lowes	London Borough of Hounslow	Assistant Director: Homelessness, Independence and Preventative Services
Annita Cornish	London Borough of Hounslow	Interim Assistant Director Special Educational Needs and Disability
Vicki Taylor	London Borough of Hounslow	Interim Assistant Director Education & Skills
Kerry Jacks	Feltham YOI	Head of Safeguards
Sarah Green	Chelsea & Westminster Hospital	Consultant Midwife for Public Health and Safeguarding
Kumal Rajpaul	HRCH	Interim Director of Nursing & Non Medical Professionals
Tony Bowen	HRCH	Named Nurse Safeguarding Children
Emelia Bulley	CCG	Designated Nurse Safeguarding Children
Parminder Sahota	West London NHS Trust	Director of Safeguarding Children and Adults
Sharon Brookes	Police	Detective Superintendent
Permjit Chadha	Community Safety	Head of Service
Clare McKenzie	London Borough of Hounslow	Children's Commissioning Manager, Public Health
Niamh Murrell	National Probation Service	Senior Probation Officer
Ian Berryman	Woodbridge Park Education Service	Headteacher (Nominated Special Schools Rep)

Kamm Grewal	Springwell School	Headteacher (Nominated Primary School Rep)
Josephine Daly	Oak Heights School	Independent School Rep
Victoria Eadie	Tudor Park Education	CEO (Nominated Secondary School Rep)
Heidi Swidenbank	Bolder Academy	Headteacher (Nominated Secondary School Rep)
Guests Attendees		
Kate Chalker Wye	West London NHS Trust	Child and Adolescent Clinical Nurse Specialist
Claire Goodhead	London Borough of Hounslow	Private Fostering Lead
Sonia Mark	London Borough of Hounslow	Private Fostering Team Manager
Sandra Weir	London Borough of Hounslow	Specialist EWO
Gerne Pieterse	London Borough of Hounslow	Reviewing & Quality Assurance Manager
Sarah Paltenghi	London Borough of Hounslow	LADO
Elaine Peers	London Borough of Hounslow	Planning and Performance Officer
Apologies		
Pauline Fletcher	North West London CCG	Associate Director for Safeguarding Children
Adam Kerr	National Probation Service	Head of Service Delivery – Hounslow, Kingston and Richmond
Graeme Baker	West Thames College	Head of Quality & Standards
Michael Michaelides	West Thames College	Executive Director Resources & Student Experience
Steven Forbes	Hounslow Safeguarding Children's Partnership	Executive Director of Children's & Adults' Services
Elizna Visser	London Borough of Hounslow	Interim Head of Safeguarding & Quality Assurance
Thomas Webster	West London NHS Trust	Named Nurse Safeguarding Children
Dr Nirmala Sellathurai	CCG	Designated Doctor Safeguarding Children
Anil Chatterjee	ARC & HYPE	Service Manager
Phil Hopkins	London Borough of Hounslow	Head of Adolescent Services
Not Attended		
Karen McLean	Homestart	Voluntary Sector Representative
Clea Barry	CAFCASS	Service Manager

1) Introductions & Apologies

Partnership members introduced themselves to the meeting. Apologies of members unable to attend were noted.

West Thames College were notified of their Ofsted Inspection and members wished them the best of luck.

2) Minutes of the last meeting & matters arising

The minutes of the last meeting were agreed and no matters arising were discussed. The action log was updated.

3) Reducing Parental Conflict and Non-Violent Resistance (NVR)

Janet Johnson and Kate Chalker-Wye summarised the report and welcomed comments and feedback.

NVR is an innovative approach to reducing family conflict, addressing violent, destructive and harmful behaviours in children and adolescents and restore individual strength and self-respect in parents. It also supports caring and respectful relationships in the family and wider community.

The Department for Work and Pensions (DWP) was leading a national Reducing Parental Conflict Programme to embed evidence-based support to tackle parental conflict in local areas. The partnership made a bid for the funding and was successful. It had been agreed that the funding would be used to support the work that CAMHS had already started on NVR a few years ago in Hounslow. Kate Chalker-Wye had trained 50 professionals including social workers, professionals from Woodbridge Park Education Service (WPES), Reach Academy and the voluntary sector.

The training was for 12 weeks, with ten people in a group. Due to Covid-19, training had moved to a virtual platform with smaller groups. Professionals who had completed the training, would receive monthly supervision from the partnership for a year to help them embed the approach with their individual families. The training was targeted at parents who had teenagers, and this would also benefit younger children in the household.

Some parents who had completed the training had attended group sessions to talk about their experience and the impact of the training on their relationship with their children and the wider family.

A support structure was being established for practitioners to use the training on an individual basis and to develop the programme. To effectively raise the profile of the approach, an event would be arranged next year, and support was needed from the partnership to build an NVR community in Hounslow. There was an indication that the funding would continue for a further three years.

The Chair assured that the event would be well advertised and supported by the partnership and requested that a paper was brought back to the Board next year on the progress of the work.

Action: For Jo Leader to liaise with Janet Johnson and Kate Chalker-Wye and agree a timescale to bring a progress paper back to the Board.

Action: For Cleo Frederick-Grant to add Reducing Parental Conflict and Non-Violent Resistance (NVR) to the forward plan.

4) Private Fostering Annual Report 2020-21

Claire Goodhead, Private Fostering Lead summarised the report and welcomed comments and feedback.

The Fostering Team had eight active cases which were referred by Children Social Care (CSC) with an element of either domestic abuse or a bereavement of a parent. All cases were allocated to a social worker and were monitored every six weeks. The team saw younger children being referred compared to previous years where they were from 14 years and older.

The Private Fostering Lead had played a key role in offering support and advice to professionals. This previously involved attending team meetings within the Intake and Safeguarding teams, to promote the understanding of private fostering, the risks to children and to ensure children's social workers

were aware of the procedure for referring privately fostered children. This had been recently revisited and would continue to raise the awareness of private fostering across the Adolescent Service, Children with Disability Team, Front Door Service and the Safeguarding Teams.

Previously, work was undertaken with School Admissions and had seen a number of early alerts which was positive. The team was receiving more complicated referrals from the Intake team however did not receive many referrals from health. The Designated Nurse for Safeguarding Children informed that private fostering was included in training for health to raise awareness.

The population of children notified as being in private fostering arrangements remained small, and this was a picture across London. The aim was to develop partnership working going forward. It was important that the partnership kept Private Fostering on their agenda as part of their safeguarding training.

Members accepted the report.

5) Children Missing Education (CME) 2020-21

Sandra Weir summarised the report and welcomed comments and feedback.

The School Attendance Order process had started, and a parent was successfully prosecuted, because they were unable to evidence that their children were receiving full time suitable education.

Fifteen children who were referred to Children Missing Education (CME) last year who had been previously home educated, had not been referred back to the team. They were successfully engaging with the Elective Home Education (EHE) team or attending the education provision named by the Fair Access Panel.

The majority of children who were referred to CME who had left in the spring term last year to go overseas, had returned to the UK and were back in schools. The hotel quarantine had been challenging financially for some families.

Schools were getting better at completing reasonable enquiries such as calling and emailing parents and in some cases making home visits if they had the capacity to do so, and making enquiries to the new Local Authority. This had allowed the team to focus on more challenging issues.

Plans for 2020/21

- During 2020/21 the Children Missing Education Policy and Off Roll Procedures were reviewed and updated. The council website has been updated with these documents and distributed to schools.

- Continue to monitor the Starters and Leavers Form from Independent Schools, to ensure they are returned on a regular basis and the return is fully completed. To support the schools if needed with help with completion.

- To continue to support Asylum Seeking families and professionals supporting them, to enable children from these families to start at Hounslow schools, including Afghanistan evacuees who have been recently placed in Hounslow.

- Continue to work with SEN and School Admissions to support children new to the country without an EHCP, to ensure they are placed in education as quickly as possible.

The team had a good relationship with partners in Health, Housing and Children Social Care (CSC). Agencies were supportive of CME and the aim was to continue to make improvements where possible.

Ian Berryman commended the CME team on the level of support, thoroughness, and robustness in making sure that children were tracked and were on role and thanked the team on behalf of all schools.

Janet Johnson briefly informed Sandra Weir of NVR which could support parents in getting their children to school. A further conversation would be held outside of the meeting.

Members accepted the report.

6) Children Social Care Annual Reports

Child Protection Chairs Annual Report

Gerne Pieterse summarised the report and welcomed comments and feedback.

During the pandemic, the new Child Protection Case Conference (CPCC) model had been embedded. The Child Protection (CP) and Child in Need (CIN) roles had been separated and were developed into bespoke and identifiable roles, in terms of roles and responsibility. Most conferences were held virtually which had improved professional engagement and had good attendance. The user feedback form was revised but was hampered due to Covid-19. A Survey Monkey was being developed to enhance the qualitative and quantitative feedback from partners and families. Going forward, the team would like feedback on the virtual conferences to consider a hybrid model to better engage families and also partners.

The Neglect Strategy was a priority for CP Chairs. The service was involved in the neglect audit and the Chairs would encourage the completion of the Quality of Care (QoC) Assessment Tool.

Timeliness for Initial Child Protection Conferences (ICPC's) was at 84% with an average in London of 81%. The ambition of the service was to be more timely with ICPCs. There had been some challenges with staffing and saw changes to all the CP Chairs over the last year which had an impact on timeliness. The last CP Chair would be starting in October 2021 and the service would be up to full capacity. The service was confident that timeliness would improve with a full complement of staff.

Review Child Protection Conferences (RCPC's) was at 97% and some of the late conferences was due to exceptional circumstances, mainly as the result of the pandemic. The volume of children subject to CP Plans had risen by 33% in the last year compared with the previous year.

There had been 78 repeat CP Conferences in the last year and this was being monitored closely and reviewed regularly to ensure the interventions were proportionate so they would not see repeat cases. The rise affected both children discharged in the previous year and from more than two years ago. There were nine Child Protection challenges, regarding nine families, relating to 21 children, raised in the reporting year. Ten children were the subject of care proceedings or PLO. The key themes from these challenges were in relation to assessment and manage of risk, intervention, and care planning.

Priorities for 2021/22;

- Develop a system which would support increase attendance/participation of children and young people as part of the Child Protection Conferences process.

- Revise the use of Child Protection/Child in Need Chair footprint and midway processes in order to support the oversight, monitoring and scrutiny of repeat child protection plans.

- Further embed a quality assurance schedule and tracking system to enhance and promote Child Protection/Child in Need oversight and challenge, including oversight of the quality of care plans to promote better outcomes for children.

- Embed the feedback forms and survey monkey for parents and professionals with regular analysis of feedback to enhance and promote ongoing improvement to practice and standards.

- Delivering on requirements of the HSCP Neglect Strategy through scrutiny and oversight over the use of the Quality of Care Assessment tool for children subject to plans under the category of neglect. This will include the use of the multi-agency chronolator and oversight from Conference Chairs to promote use of tool as appropriate.

The Chair said that there were concerns raised during the HSCP's Safeguarding Practice Reviews regarding the need for professionals to be confident to appropriately challenge at CP Conferences and safeguarding meetings. There was a need to explore training for professionals to be confident in having difficult conversations. Gerne Pieterse informed that this was an ongoing work with the new cohort of CP Chairs to ensure that challenge was helpful rather than punitive. Historically, team managers had found challenge very critical, and it was important to have a balance. Gerne Pieterse was happy to explore training around strength base challenge and would liaise with the Training and Development Manager. The CP Chairs were planning a training programme for social workers and partners around the expectation of conference and the sharing of reports with families and highlighting the conference model. This programme would support less need for challenge. Martin Forshaw said that there was less need for challenge at CP conferences as plans were progressing well which was positive.

Members representing schools raised the below concerns;

- It was a struggle to get a list from CSC of children from their school who were subject to CP and CIN plans and this had been raised with the Executive Director for Children's and Adults Services.

- Historically, schools had expressed challenges in receiving a response following a CFAN referral.

- Papers for safeguarding meetings were not being shared prior to the meeting but instead after the meetings had taken place and the minutes of meetings would take a significant length of time to arrive if at all.

- Schools would frequently request papers for safeguarding meetings.

- Not having a consistent liaison social worker.

WPES had implemented a process to track the documents that they have chased from CSC and anecdotally, this was the experience shared by other schools across the Borough.

It was agreed that further work in gathering the issues and challenges faced by schools would be undertaken at the next Secondary Partner Meeting to provide a fuller picture and presented to Martin Forshaw and Steven Forbes outside of the meeting.

Action: For Victoria Eadie to gather information from schools regarding issues and challenges they face at the next Secondary Partner Meeting.

Martin Forshaw said that schools were an integral part of safeguarding meetings and it would be unusual for them to not have that information about a child subject to a plan of support or protection in their school. Following a CFAN referral, there were systems in place for responding back to referrers therefore further investigation would be undertaken to explore the effectiveness of the process.

The Safeguarding and Quality Assurance Team would review their process around the sharing of papers and invitations prior to meetings to ensure they were done in a timely way and the sharing of minutes after meetings.

The Chair said following the findings of the dip sample and the investigation, a paper would be requested from the partnership if needed.

Action: For Martin Forshaw to explore the process in place to notify schools when children/young people are on CP Plans or CIN Plans and explore the feasibility of providing them with a list.

Action: For Martin Forshaw and Elizna Visser to explore if there is a system issue which meant some schools were being notified of safeguarding meetings after the meetings had taken place.

Action: For Martin and Elizna Visser to explore the system in place to provide agencies particularly schools with minutes in a timely way following safeguarding meetings.

Health had undertaken some work with Children Social Care (CSC) around Initial and Review CP Conferences and they ensured that 90% of GPs information was recorded on the system to support invitations to conferences. Training for professionals should include challenge and escalation. A Health and Social Care interface meeting had been set up to address some of those issues.

Members accepted the report.

IRO Annual Report 2020/21

Gerne Pieterse summarised the report and welcomed comments and feedback.

Previously each Independent Reviewing Officer (IRO) had a dual role as both IRO and Child Protection Chair. In 2020, these roles were disaggregated with five staff becoming dedicated IROs and the rest Child Protection Chairs. The stability of the service was positive and was sufficiently resourced with an average caseload of 55 children, based on a current LAC population of 255. The service was working on the timeliness for the first LAC Review and that being held within 20 working days. This had been affected by instances where the team have not been notified on time that a young person had become looked after. The IROs were not routinely getting the reports three days before the Looked After Review (LAR). The IROs were Chairing the meetings and gathering the information at the meetings rather than having the information before. A lot of young people are placed out of borough and the health and education professionals would be in another Local Authority.

Most of the challenge had been around the use of care planning and Section 20. The cases were being monitored closely and the IRO's voice was being recognised within the Case Monitoring Board. The care plan and pathway plan remained a challenge in some cases and having those updated in a timely manner. In regard to pathway plans a dip sampling of 15 cases was undertaken and 5 of the

young people did not have pathway plans in place. The IRO's have been asked to provide training and guidance to social workers to ensure the plans were meeting the children's needs and their expectation about receiving the plans within the timescales.

There was better recording of midway reviews and they were being completed more routinely. The service had seen an increase in 167% recording of midway reviews. During the pandemic a lot of the reviews were held virtually. The ambition was for IROs to have face-to-face contact with young people as part of the midway reviews to hear their views.

Priorities for 2021/22:

- Enhance the independent scrutiny of Regulation 44 visits for Westbrook and The Ride by commissioning Independent Regulation 44 Visitors.

- Enhance IRO oversight and scrutiny by further embedding a robust quality assurance schedule and tracking system, including embedding learning from audit activity in practice.

  The schedule for 2021/22 will include:

  - Midway reviews, that will include speaking to children where appropriate.
  - The Needs Assessment to inform LARs and care plans.
  - The use of consultation forms with children, foster carers, parents, and key workers.
  - Contact with families including siblings.
  - Greater participation of younger children in LARs.
  - Use feedback to develop and inform practice.

- Support placement stability and permanency planning improvements through redesigning IRO LCS Forms to include reference to FGCs, permanency planning, changes in care plans and long-term fostering matches.

- Re-launch and embed the IRO resolution process and reporting arrangements to increase the impact of IRO intervention in quickly identifying, escalating and addressing any emergent issues of concern.

- Improve the completion of LAR's and LAR minutes within expected timescales.

- Improve mid-point meeting process to ensure all children and young people have a midway review in between their LAR and this is clearly recorded on LCS. Practice guidance will be developed to strength and embed this process.

One of the changes from last year was that the minutes were written to the young people instead of about them. Some professionals have found it difficult in terms of adjusting but the approach was child focus and the feedback from the IRO was that it was positive in writing the minutes in this way.

The Chair thanked Gerne Pieterse for a comprehensive report and members accepted the report.

LADO Annual Report 2020/21

Sarah Paltenghi summarised the report and welcomed comments and feedback.

In 2020, two permanent LADO's joined the service. Both LADO's work part time, however the LADO service was fully covered by their working patterns. A permanent Business Support Officer was also appointed in 2020. The LADO's have been working to raise the profile of the service across the

borough with a view to embedding a standalone LADO Service. This had resulted in most referrals coming directly to the LADO rather than being screened by the CP/CIN Chairs and this has provided a more effective and timely response.

Last year, the LADO service received 135 referrals and 51 were referred by Education. Following investigation safeguarding advice was given to 71 cases and 56 were escalated to Allegation of Staff and Volunteers (ASV).

The LADO's have continued to raise the profile of the service across the borough and has provided briefings to Adult Safeguarding, Children Social Work Teams, and the MASH with regards to Allegations Against Staff procedures and LBH local protocol.

An action plan had been developed for 2020/21 which had four areas of improvement.

- Continue to improve referral and tracking processes
- Raising the LADO profile and awareness of LADO process
- Strengthen quality assurance arrangements
- Improve LADO arrangements with Feltham YOI and strengthen the safeguarding arrangements related to managing allegations

A standalone spreadsheet has been created to provide an accurate record of all communications, including consultations, safeguarding advice, referrals and signposting to other agencies.

Members were reminded that they could contact the LADO directly if they had any questions or concerns.

The Chair commended Sarah Paltenghi and Grace Murphy on the exemplary work that had been undertaken with Feltham Young Offenders Institute which had contributed to the recent positive outcomes in their inspection and comments made about the establishment. The Chair formally thanked them both.

Ian Berryman thanked the LADO for their continuous advice and support.

Members accepted the report.

Quality Assurance Annual Report 2020/21

Elaine Peers summarised the report in the absence of Elizna Visser and welcomed questions and comments.

The report focussed on the case audit programme, dip sampling activity and user feedback.

In January 2020, Ofsted Focus Visit highlighted case audits as an area of development. To improve the accuracy and effectiveness of case audits, the team had refreshed the existing case audit process to encourage direct engagement with the Social Worker, address the lived experience of the child and focus on impact and learning. An annual case audit report for 2020/21 provides evidence that this process is now well-embedded.

In July 2021, a subsequent Ofsted Focus Visit took place and the findings of the internal audits had been effectively challenge through moderation. The case audit programme was helping to develop a shared understanding of what good practice looked like across the service. There was a high level of monitoring and oversight of audit outcomes, including a quarterly report which was being presented to the Safeguarding Effectiveness Sub-Group.

The service priorities were aligned with the partnership's priorities and over the year they have been using the audits to be assured about their neglect practice.

Audits were undertaken on Return Home Interviews to track young people who were missing from home and care. The service was exploring the issues around life story practice and how it could be improved. A summary of a comprehensive programme of dip-sampling activity and learning was attached as Appendix 2. The main areas for development for the previous year was to ensure the Quality Assurance cycle was completed.

A number of methods were in place to seek feedback from parents, carers, and young people about their experiences of the service. Family feedback forms were completed at all Child Protection Case Conferences (CPCC) to rate the conference, reports, and impact/outcomes of the Child Protection process from the families' perspective. User feedback was embedded in case audit programmes and was looking at more ways to use user feedback to develop the service. Ofsted commented in the most recent inspection that having user feedback from children was adding richness to their findings.

The priorities for 2021/22 was focussed on ensuring that the quality assurance activity was well embedded and was providing assurance across practice.

Members accepted the report.

7) HRCH Annual Report 2020-21

Tony Bowen summarised the report which was circulated to members prior to the meeting.

HRCH experienced an exceptionally busy year in 2020, due to the pressures of the pandemic. Three members of the safeguarding team were redeployed which had an impact on the team. In regard to the key performance indicators, the team had done well. There had been good compliance from staff regarding Safeguarding and Prevent training. It was noted during quarter 3 and 4 that training compliance for level 1 and 3 dropped below the 90% target. A level 3 training package was identified by the learning and development team and reviewed by the Named Nurse for Safeguarding children.

The Trust had continued to prioritise supervision for staff members which was reflected in the high levels of compliance achieved across most clinical teams.

MASH Health checks were extremely busy and had continued to be busy. Data was being collected manually and the timescale for reporting had been sustained.

The Trust had undertaken training with the Health Visiting Service on the use of risk assessment tools, completion of referrals to children's services and report writing.

The effective use of the Quality of Care Assessment Tool had continued to be a priority for 2021/22. The organisation had undertaken a lot of training with staff regarding the quality of CFAN referrals and it would be helpful to receive feedback. A Health and Social Care Interface meeting had been recently set up and it would be useful to address some of the issues from a health perspective. The Complex Case Panel would also have an impact in addressing challenging cases. Emelia Bulley informed that the MASH was discussed at the meeting on the 29th September 2021, and further exploration of the data would be undertaken.

Tony Bowen requested that the partnership was mindful of workload within health when arranging its programme of work.

The Chair said that the Front Door service has been under a lot of pressure regarding the volume of referrals being received.

Sarah Green said that it would be important to know how the maternity service was feeding into the MASH process and as they move to a wider North West London perspective, and should consider co-location in the MASH. The maternity cases are getting complicated and should be explored. Tony Bowen agreed.

Members accepted the report.

8) Chelwest Annual Reports

Safeguarding Children Annual Report 2020-21

Sarah Green summarised the report and welcomed comments and feedback.

The organisation had designed a Level 3 safeguarding training package with a 'Think Family' approach which covers Children and Adults at level 3 Safeguarding. This would be held via zoom. Initially, this was developed for maternity, but Paediatrics had come on board which was positive. The Trust had a compliance level of 88% for Level 3 training which was due to Covid-19 and the redeployment of staff.

A Perinatal Mental Health Hub was available across North West London which consisted of midwives and psychologists providing additional psychological support for women who have suffered Birth Trauma, pregnancy loss and any on-going mental health concerns during pregnancy/ following birth.

Further work was being undertaken from a National perspective to explore the underlying trauma in women which is important, and in the future consideration would be given to women who have had the children removed.

Multi-agency meetings were in place. A monthly multi- agency meeting takes place across both paediatrics and maternity on both sites in order for staff to present cases with the Multi-agency partners however there had been challenges due to the pandemic.

Clinical governance meeting continued to take place within the paediatric and the maternity teams and key safeguarding cases were presented such as lessons from Serious Case Reviews.

The Safeguarding Midwives at West Middlesex University Hospital and the perinatal mental health midwife attend the Hounslow Social Care meeting to discuss any new safeguarding referrals which was useful and was a good example of working together.

The Trust had recently undertaken work with the Home Office around stability for asylum seekers when they were pregnant.

In July 2020, a new pilot programme called Supportive Signposting was launched within the maternity service which was based on the Social Prescribing Model based in Primary care and was one of the recommendations from the consultant Midwife Public Health and Safeguarding Msc research to increase referrals to early intervention and Early Help services. The programme was demonstrating positive programmes and the majority of contacts were from Hounslow with Housing and finance needs identified as the key issues. An evaluation was completed which showed that this had improved people's emotional well-being by 70%, which was significant.

The Trust had a Child and Adolescent Mental Health Services supported by the mental health liaison services during the week and an out of hours psychiatric liaison crisis services across both sites.

There was a dip in referrals from the Chelsea and Westminster site and as a result a generic safeguarding inbox was set up to ensure consistency across the safeguarding referrals. A deep dive audit was undertaken which showed that the midwives were not copying the safeguarding team into all social care referrals via the generic safeguarding inbox.

The Trust would be piloting a maternity vulnerability threshold document which had been designed jointly by Kings College and REACH Academy with a particular focus on vulnerability within families within the maternity system. It has received positive feedback during training and was expected to help staff feel confident in being able to identify cases that meet safeguarding threshold and those that can be managed within the community teams.

WPES managed the hospital school, and there had been a significant increase in admissions for child mental health. There seemed to be a significant lack of appropriate placements for the children who were clearly assessed as needing further mental health intervention such as residential placements. The Lead teacher of the hospital school was consistently raising concern and there were children on the hospital wards for a long time needing intervention.

Emelia Bulley said that it was important that when staff raised concern the escalation route was used.

Martin Forshaw said that Tier 4 beds and specialist placements was a national issue. A meeting was held recently with West Middlesex and Hounslow Commissioning Team around the issue of discharge planning for vulnerable teenagers however the outcome was not known.

Members accepted the report.

9) NWL CCG Annual Report 2020-21

Emelia Bulley summarised the report which was circulated to members prior to the meeting and welcomed comments and feedback.

The report was produced in collaboration with the eight CCGs serving the boroughs of Brent, Ealing, Harrow, Hammersmith and Fulham, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. It covered Adults, Children and Looked After Children and a period where the NHS was responding to a global pandemic.

A North West London Safeguarding Hub was set up to provide continuity for the statutory advisory safeguarding services while responding to the pandemic and the Designated professionals had continued to engage with partnership work.

The NWL CCGs have continued to complete Safeguarding Health Outcome Framework (SHOF) on a quarterly cycle although at times it was not timely or fully completed due to the pandemic.

The Designated professionals had continued to be invited to provider Safeguarding Committee meetings for support and scrutiny and it was observed that there had been an escalation of complex and severe safeguarding cases.

From 2019, the NHS had a long-term plan that continued to be implemented which sets out the ambition that every part of the country should be in an Integrated Care System (ICS) by 2021. The NHS was changing and moving away from the competitive approach to health care towards

collaboration between health organisations, focused on reducing inequalities in access to health services and delivering equality of outcome. The ICS would be in place in April 2022.

The NWL CCG would progress development of a CSA Hub model, based on an adaptation of the Child House Model of international best practice, drawing together medical, investigative, and therapeutic services all under one roof.

In March 2021 there was significant media interest in the website "Everyone's Invited", with the movement committed to eradicating rape culture in schools. NWL CCG had worked with Primary Care Team and provided guidance to support GPs in recognising specific health needs and safeguarding concerns in patients who are refugees or seeking asylum.

The CCG had supported the Neglect Strategy and worked with the Local Authority Community Safety Team on the Violence Reduction plan. The CCG supported the Single Point of Contact to improve the attendance and contribution at strategy meetings and Child Protection Conferences.

The organisation was seeking to improve the offer and integration of Looked After Children (LAC) who had special educational needs and disability, and have escalated risk where LAC children who were placed out of borough were not included in the contracts for the local health provider for health monitoring.

Members accepted the report.

10) Ofsted Focused Visit on Extra Familial Harm Outcome

Martin Forshaw summarised the report which was circulated to members prior to the meeting and welcomed comments and feedback.

An Ofsted Focus Visit to Hounslow Children Services was undertaken on 14th and 15th July 2021. The headline finding was that most children considered to be at greatest risk of extra familial harm were being identified and received an appropriate response.

The areas of improvement highlighted were:

- The routine engagement of children in return home interviews and in the completion and review of assessments regarding extra-familial harm.

- Work with partner agencies to ensure that the threshold for referral and child protection strategy discussions is understood and that sufficient information is provided at the point of referral and in the multi-agency safeguarding hub.

- Capacity in the relevant teams so that all children at risk of extra-familial harm receive a more timely response when they need help and protection, including in response to serious incidents.

The challenge was around the demand and the expectation of the Front Door Service. The volume of referrals coming through to the Front Door and the resources needed to filter through the information was significant and this had an impact on the rest of the service. There was an urgent need as a partnership to address the issue. It was the responsibility of each agency to ensure that the referral was of sufficient quality and standard and had the required information to allow CSC to make a decision about threshold for intervention rather having to request further information which was time consuming.

Ian Berryman said that the volume and pressure on the front door has been an ongoing conversation for some time. From his perspective, the allocation of social workers to schools had made a considerable difference and was a positive step forward. The link meetings, if they are set up properly would be a step forward in terms of filtering out the information. There was a need to understand why it was so difficult to address this issue. Kamm Grewal commented that she was concerned that schools send a referral for children that they are concerned about. If the referrals were not meeting the threshold, there was no guidance for schools to follow and advise where the referrals would go for concerns to be addressed.

There were previous conversations about the matrix being added to the CFAN and whether the threshold document had been shared with schools and there were concerns that the conversation would be repeated if it was not addressed.

Jo leader informed that it was a statutory requirement and outlined in Working Together 2018 for a partnership to publish a local threshold document on their website so all agencies should be aware of its existence. The 2021 updated version was sent to schools via the HSCP DSL list and schools had received information about it as part of the HSCP safeguarding presentation Headteachers in June 2021 and the slides had been circulated. A question about understanding the document and it's application within schools and inclusion in their safeguarding policies had been included in the Annual Safeguarding Audit of schools for the last 3 years and the analysis of the responses from schools had never raised a concern about schools not being aware of or not understanding local thresholds.

The Chair informed that a discussion would be held at the next Executive Partnership Board in October 2021, regarding undertaking an audit of the referrals to the Front Door Service to try to address the issue particularly the inappropriate referrals. Members agreed with the Chair's recommendation to undertake an audit.

Janet Johnson asked about the progress with digitalising the CFAN. Prior to Covid-19, work was undertaken with the Early Help Hub regarding training to improve the quality of CFANs and suggested guidance was added to the CFAN. The Early Help Hub was using the guidance to talk to professionals who were contacting them about the quality of referrals. The guidance was shared with health who found it useful to use it in their training to support practitioners in writing an appropriate referral. A number of the referrals may not meet the threshold for social care intervention and would meet the threshold for Early Help.

Martin Forshaw said in terms of digitalization a bid was submitted to the Council, who were investing £350,000 towards improving a range of system but not specifically the CFAN. The funding for the Early Help Hub had been extended for another year however analysis showed that the biggest refers to the Early Help Hub was the Front Door.

Emelia Bulley said that everyone had an interest and responsibility to make sure that Front Door was working in the way that it should. This conversation had been ongoing for two years and there was a need to explore the problem to look at the key issues. One of the reasons why the Health and Social Care Interface meeting was set up was drill into the key issues that were causing the volume of these referrals. The meeting highlighted areas such as what CSC see a gap in information would not actually be a gap because of the context of the referral and there was further work to be done.

Ian Berryman asked if consideration was given at a Senior Level to the potential 'cliff edge' when the funding for the Early Help Hub ceased and what would that mean for the Front Door Service. WPES used the Early Help Hub and some of their young people had social workers. Ian Berryman had seen a lot of comprehensive information regarding the hub and asked if something had gone wrong with its promotion.

The Chair said that a paper on the progress of the Early Help Hub was due to the Board but had been delayed and it was important this was presented at November's meeting. The issues raised at the meeting would be presented to Claire Bridge.

Action: For Martin Forshaw to present an assurance paper on the Early Help Hub to the partnership in November 2021.

11) 0-25 Disability Team Assurance Progress Report

Annita Cornish summarised the report which was circulated to members prior to the meeting and welcomed comments and feedback.

The last report which was presented to the Board highlighted concerns in the 0-25 Disability Team and members did not feel assured although there was an intense service improvement plan in place.

There had been further disruption to the team as a result of the team manager leaving. The team that was now managing children from 0-17+ and had reverted back to Children with Disability Social Work Team and remain in the SEN and Disability Service. The 18-25 Social Work team would continue to have a focus on transition to maintain expertise in this area. The 0-25 Disability Team was not achieving the outcomes it was intended and created a lot of challenges in trying to manage two different systems across children and adults. However, having worked with Adult Social Care, there had been an improvement in communication between children and adults.

A new Team Manager had been appointed and so far his analysis of the progress of improvement showed variable success however the team was on the trajectory of improvement in quality of the work.

There had been an improvement with statutory visits being completed on time. There had been 100% of assessments completed around for Looked After Children. There was a good focus on updating the improvement plan to make ensure that the statutory visit form was being implemented. The dip sampling showed that the quality of practice had improved.

The team was working on developing the use of materials and focus on children's voice during visits and ensure they are spoken to. This was more challenging with children with disabilities but there were staff within SEND who were skilled and could offer support to the disability social work team.. Direct work had been identified for training.

There was ongoing work on improving assessment and timeliness. Feedback was given to the Performance Learning Board and a meeting was scheduled to Review the improvement plan. There were still challenges with some cases and performance not being accurate because of the way it was being reported.

The Chair commented that progress was being made but it was slow and requested that progress reports should be presented at every meeting until members were fully assured. This would be added to the Board's forward plan.

Members accepted the report that the team was on a journey and agreed with the Chair regarding progress reports.

12) HSCP Strategic Plan 2021/23

Jo Leader summarised the plan to members and welcomed comments and feedback.

The partnership had moved away from a Business Plan to a Strategic Safeguarding Plan. Underneath the plan would be a succession of work plans to deliver the overarching plan across the structure of the partnership.

The Strategic Safeguarding Plan sets out the strategic commitment of the partnership priorities and would form the basis of its work over the next two years. This was presented to the Executive Partnership Board for agreement in August 2021 and shared with the wider partnership Board for comments. There were four priority areas, two which, neglect and Child Sexual Abuse which were carried over from the previous two-year business plan to ensure that outstanding work was completed and proper assurance could be sought.

The two new priorities were vulnerable children in education and children with disabilities and SEN. The priority was identified through the partnerships learning and quality assurance activity including the Serious Youth Violence Systemic Review. An ongoing Local Child Safeguarding Practice Review und featured issues in relation Elective Home Education (EHE) and safeguarding issues which is also an area being addressed by the National Panel. This demonstrates in part that the HSCP is picking up on both local and national safeguarding priorities.

Jo Leader asked members to send their comments on the plan within two weeks at which point it would be published on the partnership's website.

Emelia Bulley said some issues had been escalated to her form Named professionals that there was a lot of activity going on within the partnership that was impacting on their work within the organisations. It important to be mindful of the amount of work that was being planned to make sure that they were not overloaded.

Jo Leader said that this should be discussed at the Executive Board meeting as they are responsible for setting the agenda and expectations of the partnership work. Much of the partnerships programme including the quality assurance programme was agreed in advance at the start of every financial year unless responding to a new and emerging issue.

13) Complex Case Panel

Jo Leader summarised the background of the Complex Case Panel.

The partnership had identified through its learning and quality assurance activity particularly Child Sexual Abuse (CSA), neglect and case learning discussion in the Cases Sub-Group that there was not a forum to support agencies to address issues which have not made sufficient progress through appropriate channels and escalation routes within established multi-agency processes such as Child Protection Conferences.

The criteria of the panel would be tight, and the membership would be a multi-agency group of senior leaders and decision makers of partner organisation who have the authority to influence and make decisions and commitments in the meeting from their services perspective.

The Chair asked members to send any comments or feedback to Jo Leader on the Terms of Reference (ToR) particularly the core membership. It was important that the right professionals were represented to break down barriers and allocate resources in order to get speedy resolutions.

Permjit Chadha informed that there was a lot of work being undertaken the Community Safety around the subgroups that are reporting to the Community Safety Partnership Board. Following a review last year, it was a recommendation to look at the effectiveness of the partnership and how it

interfaces with other strategic partnerships and how the subgroups interface when there was an issue around crime and community safety. Permjit suggested that she had a conversation with Jo Leader outside of the meeting to discuss any potential crossover or collaboration opportunities with Community Safety risk panels.

Action: For members to review the core members for the complex case panel and send comments to the Chair and Jo Leader.

Action: For Jo Leader and Permjit Chadha to have a conversation regarding the complex case panel and discuss any potential crossover or collaboration opportunities with Community Safety.

14) Safeguarding Children within HRCH Presentation

Tony Bowen gave a presentation on the current safeguarding children arrangements within the CCG and the safeguarding arrangements in the emerging Integrated Care Systems.

Tony Bowen took members through the structure of the team. The health economy was structured differently to that of the Local Authority. The Executive Lead was the Director of nursing and non-medical professionals. The Safeguarding lead who sat underneath the Director was the Named Nurse, Tony Bowen. There was one Deputy Named Nurse and two specialist nurses for safeguarding children. There was a MASH Practitioner and MASH Business Support Officer. There were two Named Doctors for Hounslow and Richmond who sit within the safeguarding team but came under the operational children services. There was a Named professional and specialist nurses for Looked After Children for both localities and they sat with the operational children services.

There was a governance structure in place and Safeguarding Committee which fed into the Quality Governance Committee, Hounslow CCG and Richmond CCG and then to the Executive Committee. Both Designated Nurses for Hounslow and Richmond attended the committee.

HRCH was required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service it delivered. The Trust must demonstrate safeguarding is embedded at every level within its organisation with effective governance processes. HRCH must assure itself, their regulators, and commissioners that safeguarding arrangements are robust and are working effectively.

Below were some of the roles of the Named Nurse and Doctor across Hounslow and Richmond.

- The Named Nurses and Doctors provide professional and clinical leadership on safeguarding children services within their own organisations and ensure that a coordinated and integrated safeguarding service is provided.

- Named Nurses and Doctors ensure that services are delivered in accordance with the HRCH safeguarding Children Policy and that there are safe systems and processes in place for staff.
- Named Professionals have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

- Named Nurses and Doctors in collaboration with the Designate Professionals are responsible for promoting good professional practice and providing specialist advice and support to health professionals within their organisation on any issue relating to safeguarding children.

- The Named Nurse attended a number of Safeguarding meetings across Hounslow and Richmond therefore the partnership should be mindful of the workload.

The Named Nurse sat on both partnership Boards for Hounslow and Kingston and Richmond. The Deputy Named Nurse and Specialist Nurse would attend on behalf of the Named Nurse to give advice and support if meetings co-aligned. Specialist Nurses would attend operational meetings including Hounslow MARAC.

Tony Bowen took members through the function of the safeguarding team including the provision of safeguarding supervision to 23 teams working with children and young people. Both operationally and clinically the team was working directly with practitioners to ensure they were safeguarding children effectively. The team attended a number of meetings included Strategy Meetings, Child Protection Conferences and core group meetings. There was a number of training provided to staff via a range of routes such as Hounslow Virtual College and Achieving for Children.

The Chair requested that the presentation was shared with Cleo Frederick-Grant. Subsequent to the meeting the presentation was shared with the partnership.

15) AOB

Update on probation unification

Due to time constraints the Chair requested that Niamh Murrell provided an update on probation unification via an email to Cleo Frederick-Grant. Following the meeting, the below update was circulated to members.

The Probation Service reunified on 26 June 2021. All aspects of casework that were split between the private and public sectors are now retained under public sector control. Former CRC staff have transferred over and operational activities for Hounslow are managed within the Hounslow Kingston and Richmond Probation Delivery Unit, the Head of Service was Adam Kerr. All the PDU operational activities (excluding court work) are now operating out of one site - Kew Foot Road in Richmond. Throughout the pandemic/lockdowns we have retained face to face contact with those people on probation who present the highest risk/highest level of complexity including those where there are safeguarding concerns.

NPS London have now signed the 2021 published pan-London data sharing agreement for Child Safeguarding. All Probation practitioners are familiar with their responsibilities in respect of data share and the procedures that apply.

FYI HSCP Adolescent Safeguarding Strategy

The paper was to inform members of the strategy.

Thank you

Members thanked Emelia Bulley for her dedication and commitment to the partnership over the last two years and wished her the very best in her new role.

AGENDA (Part B – CONFIDENTIAL)

The Part B minutes of the last meeting were agreed and no matters arising were discussed.