# Hounslow Safeguarding Children Partnership

# Annual Report

# 2021-22

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## 1) Foreword from the Independent Advisor and Chair

This annual report covers the period 1st April 2021 to 31st March 2022 and is my sixth annual report since appointment as independent chair of the partnership in October 2016. The annual report is the opportunity 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.

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.

In last year's statement of assurance, I set out a number of issues I was not fully assured on. This statement of assurance will briefly highlight progress on these issues. More detailed information as well as an overarching comprehensive framework of assurance for the partnership is contained in the body of the report.

This annual report will be presented to the health and well-being board for information and there is an expectation that agencies will take it to their appropriate board or key governance structure.

Hannah Miller OBE,

H. Miller

Independent Chair and Adviser

Hounslow Safeguarding Children Partnership

## 2) Statement of Assurance from HSCP Independent Advisor

### Towards Achieving Positive Assurance

### Partnership Members Views

At the independently facilitated Challenge Days held in March 2021 and May 2022, members were assured that the safeguarding system in Hounslow is safe, effective and responsive to emerging need by acting on learning identified.

### Statutory Annual Reports

**T**he annual reports were presented to the partnership board for challenge and scrutiny.

### Multi-Agency Audit Programme

An important part of the assurance process is external audit. External audits of Neglect and Front Door referrals to social care were commissioned in 21/22.

**Rapid Reviews**

No local rapid reviews were held this year. Two cases of long- term chronic neglect were the subject of local safeguarding practise reviews. Learning from these reviews has been incorporated into multi-agency training.

**Inter-familial Child Sexual Abuse**

A strategy has been agreed and a training programme rolled out to front line staff and managers during 2022 with a future audit planned for 2023. This issue will remain as a priority for the partnership until the re-audit.

**Feltham Youth Offending Institute- Safeguarding Issues**

Regulatory visits have continued to report favourably on safeguarding measures taken to protect boys. The FYOI sub-group of the partnership continues to provide a high level of support and challenge to the institution.

**Data Provision and Analysis**

Data issues have made good progress following the intervention of the Executive Group both in terms of provision of data and single agency quality assurance information.

**Voice of the Child/Outcomes for Children**

Progress has been made by the partnership in capturing the voice of the child.

**Quantity and Quality of CFANS/Threshold Issues**

An external audit of 50 referrals to the social care front door has made a number of recommendations for improvement that are subject to an agreed partnership action plan

**Serious Youth Violence**

After a slow start, the partnership sub-group set up to progress the recommendations of the systemic review (2020) has made good progress and is ready to launch a formal multi-agency adolescent strategy.

**MACE**

The issues flagged 20/21 with regard to the operational MACE have been resolved with new terms of reference, improved chairing and a clearer focus on outcomes.

**CAMHS**

The Executive Group and the partnership have received reports to provide some assurance that existing scarce resources are being effectively deployed to reduce

waiting times for assessment and to provide advice and guidance to families with children on the waiting list.

**Home Schooling**

A local child safeguarding practise review highlighted national issues with regard to eligibility for home schooling. A partnership priority for 2021/23 is vulnerable children in education, which includes elective home schooling.

**Requires More Assurance/Evidencing of Outcomes**

**Neglect**

The results of the external audit of neglect cases were very disappointing given the resources that had been devoted to improving this key area of safeguarding over a number of years. A task and finish group has reviewed every aspect of multi-agency work in this area and as well as additional training for staff are monitoring the mandatory use of the partnership quality assessment tool in all neglect cases. I am assured that agencies are working hard to improve practise and consider a further external audit should be commissioned next year to evidence that improved outcomes for children have been achieved.

**Domestic Abuse**

The community safety partnership is taking the lead in implementing recommendations from the systemic review (2020). Formal assurance needs to be provided to evidence recommendations are being implemented and improved outcomes delivered for children.

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

The community safety partnership has the strategic lead on these issues. Formal assurance is needed to evidence that children are not being placed at risk of harm and that appropriate prevention strategies are in place.

**Early Years**

The partnership will look for assurance that the government funded Family Support Hubs will deliver outcomes for children that keep them out of the child in need/child protection processes.

## 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 2021/22 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. From May 2021 the Partnership Executive Board has implemented a strategic 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 2021/22 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 2021-23:**

1. Neglect
2. Child Sexual Abuse
3. Vulnerable Children in Education
4. Children with Disabilities and SEN

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, subgroups, training evaluation, learning from the multi-agency case reviews and audits, and assurance and monitoring activities.

## 4) Hounslow's Context

### Population

Hounslow is the 10th largest London Borough (out of 32) in terms of geographical area and current estimates show Hounslow to be 19th largest by population (272,976). 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 2021 shows that in Hounslow the population age 0 to 17 years is approximately 65,773 and makes up 24.2% of the total population. GLA projections show that in 2022, the size of the 0-4

years age group is expected to be 18,500 (6.7% of the population), in 2023 is expected to be 18,000 (6.5% of the population) and in 2026 is expected to be 17,200 (6.1% of the population).

## 5) Governance & Accountability

### Scrutiny of HSCB Annual Report 2020/21

The annual report for 2020/21 was written to comprehensively reflect the work undertaken for the year and approved by the Partnership in September 2021. 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. 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 information and challenge. Annual Reports, which have been considered during the year, include:

- PREVENT and Counter Extremism Annual Report 2020-21
- Children Missing Education (CME) Annual Report 2020-21
- Child Protection Chairs Annual Report 2020-21
- IRO Annual Report 2020/21
- LADO Annual Report 2020/21
- Quality Assurance Annual Report 2020/21
- HRCH Annual Report 2020-21
- Safeguarding Children Annual Report 2020-21
- NWL CCG Annual Report 2020-21
- Elective Home Education 2020-21
- Traveller Education Team Report 2020-21
- WL NHS Trust Safeguarding Annual Report 2020-21
- MMPR Annual Report 2020-21
- Chelwest Learning Disability and Transition Annual Report 2020-21

The partnership did not receive an annual report in relation to Private Fostering for the second year running 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 ensures that safeguarding children and adults is considered, prioritised and cross cutting priorities are jointly achieved. One meeting took place in November 2021 and this function is now covered within the Executive Board which convenes four times a year. Key strategic partners attend and contribute to the evaluation of the effectiveness of the HSCP as a whole.

## 6) Challenge, Assurance, & Scrutiny

The work to improve the partnerships' challenge and scrutiny function has continued to develop and expectations set by the Chair have been further embedded.

**Challenge Day 2021**

The Challenge Day was well attended by all partners and focused on reviewing the Business Plan, the effectiveness of the partnership and the Think Family agenda of both the Children and Adult Boards.

**Scrutiny and Oversight**

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

- Adolescents Safeguarding Strategy
- Threshold Document
- HMIP Inspection of Feltham YOI
- Health inclusion in the safeguarding system
- Core statutory safeguarding service delivery coming out of Covid-19
- CAMHS Service Delivery
- Children Social Care Improvement Plan
- Domestic Abuse Systemic Review
- Reducing Parental Conflict and Non-Violent Resistance
- Neglect Audit
- Local Area Self-Evaluation of SEND
- Universal 0-5 Pathway and Offer
- Early Help Hub Progress
- Core statutory safeguarding of vulnerable children who have disengaged from education following Christmas break
- West Thames College Ofsted Inspection

**Adolescent Safeguarding Monitoring and Oversight Group (ASMOG)**

There has been considerable improvement to ASMOG since the last annual report. Representation from health, social care and the police is now strong and there are mechanisms in place to enable colleagues to be actively engaged in all aspects of this work programme. Securing regular representation from education remains a priority.

Social care has progressed work on some identified weaknesses in practice including better recording and monitoring of key adolescent safeguarding and exploitation activity, including missing young people. Risk factors can now be recorded so that progress can be monitored in a more systematic way. In future, the local authority will provide reports with firm evidence of activity.

Steady progress has been made on the implementation of the Serious Youth Violence recommendations and action plan.

Priority for 2021/22 is the development of a dataset capturing different aspects of vulnerability so that there is a shared problem profile.

## 7) Safeguarding in Hounslow Multi-Agency Safeguarding Hub (MASH)

- There were 22,521 contacts recorded in LCS between 01 April 2021 and 31 March 2022, of these, 1,196 (5.3%) were considered for MASH checks, which shows a reduction of 0.5 percentage points on 2020/21 when it was 5.8%.
- The most common reason for contact being made was Early Support (25.7%) followed by family breakdown/crisis (17.6%) and domestic abuse (12.7%)
- The top three referring agencies continue to be Police (35.6%), Health (17.4%) and Education providers (16.8%).

| **MASH** | 2021/22 | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|---|
| No. of AMBER and GREEN contacts considered for MASH checks | 1110 | 1194 | 1378 | 1410 |
| % of contacts considered for MASH checks* | 5.3% | 5.8% | 7.3% | 7.5% |
| % of contacts received from agency - police | 35.6% | 35.3% | 34.0% | 35.0% |
| % of contacts received from agency - education | 16.8% | 12.1% | 14.7% | 14.8% |
| % of contacts received form agency - health | 17.4% | 17.8% | 17.7% | 17.3% |
| % of contacts received from agency - adult social care | 5.7% | 7.1% | 7.1% | 8.2% |
| % of contacts received from agency - probation | 2.2% | 2.0% | 5.6% | 4.0% |
| % of contacts received from agency - individual | 7.0% | 7.3% | 6.4% | 6.0% |
| % of contacts received from other agencies | 4.1% | 4.3% | 11.0% | 10.7% |
| The most frequent reason for contact | | Early Support (25.7%) | Family Breakdown/Crisis (17.6%) | Domestic Abuse (12.7%) |
| % of contacts RAG rated RED following MASH checks | 26.7% | 21.9% | 28.9% | 33.0% |
| % of contacts RAG rated GREEN following MASH checks | 4.4% | 17.0% | 52.7% | 50.7% |
| % of checks for all agencies completed within 24 hours | | - | - | 68.4% |

## Front Door

- The percentage of repeat referrals received in 2020/21 was 19.4%, a decrease from 22.1% in 2020/21.
- The percentage of referrals received that progressed to a Children and Families Assessment during the year was 85.7%, this follows a continuing downward trend since 2017/18

- 92.0% of assessments completed in the year were completed within 45 working days. This is a reduction from 96% in 2020/21, however still well above the national average.
- The final percentage of Initial Child Protection Conferences (ICPCs) held within 15 working days during 2021/22 was 69% and shows a reduction from 90.0% in 2020/21.

| **Front Door** | 2021/22 | 2020/21 | 2019/20 | 2018/19 | 2017/18 |
|---|---|---|---|---|---|
| No. of contacts completed | 22,521 | 20425 | 18,958 | 18,942 | 26,759 |
| % of contacts completed that led to a referral | 14.6% | 13.1% | 15.3% | 17.2% | 9.6% |
| % repeat referrals started within the last 12 months | 19.4% | 22.1% | 17.4% | 18.1% | 15.3% |
| % referrals completed which led to a multi assessment | 85.7% | 87.1% | 90.0% | 91.2% | 96.4% |
| % of multi assessments completed within 45 working days | 92.0% | 96% | 66% | 73.5% | 79.2% |
| % multi assessments completed with an outcome of NFA | 41.3% | 36.5% | 47.5% | 47.8% | 44.4% |
| No of Section 47s started | 1065 | 1103 | 855 | 818 | 693 |
| No of completed S47s with an outcome of ICPC | 373 | 472 | 293 | 306 | 188 |
| % of completed S47s with an outcome of ICPC | 35.6% | 39.3% | 41.8% | 36.9% | 30.2% |
| % ICPC occurred within 15 working days of start of S47 enquiry | 69.0% | 90% | 81% | 66.6% | 84.6% |

## Child Protection

- The final percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time during 2021/22 was 16.6% (42 children) and shows a decrease on the percentage of 24.6% from 2020/21.
- The final percentage of Child Protection Plans ending after 2 years or more during 2021/22 was 4.5% (14 children)
- The percentage of children with a current Child Protection Plan lasting 2 years or more as of 31 March 2022 was 0.0% (0 children). This is a reduction from 2.4% (2 children) as of 31 March 2022.

| **Child Protection Plans (latest category)** | 2021/22 | 2020/21 | 2019/20 | 2018/19 | 2017/18 |
|---|---|---|---|---|---|
| Number of CP Plans for Emotional Abuse | 93 | 122 | 73 | 81 | 78 |
| Number of CP Plans for Physical Abuse | 5 | 10 | 11 | 5 | 7 |

| | | | | | |
|---|---|---|---|---|---|
| Number of CP Plans for Neglect | 90 | 110 | 93 | 141 | 133 |
| Number of CP Plans for Sexual Abuse | 2 | 6 | 10 | 18 | 11 |
| Number of CP Plans for children with disabilities | 13 | 16 | 4 | 14 | 21 |
| Percentage of children becoming subject of a plan for a 2nd or subsequent time | 16.6% | 24.6% | 18.5% | 14.1% | 15.6% |
| Number CP plans ended after a period of 2 years or more | 14 | 2 | 25 | 19 | 15 |
| Percentage of Child Protection Plans ending after 2 years or more | 4.5% | 0.8% | 8.4% | 6.5% | 5.2% |
| Number of children with a current CP Plan lasting 2 years or more | 0 | 6 | 0 | 11 | 15 |
| Percentage of children with a current CP Plan lasting 2 years or more | 0% | 2.4% | 0% | 4.5% | 6.6% |

**Comparator Data for Child Protection per 10,000**

| **Child Protection Plans** | **2021/22** | **2020/21** | | |
|---|---|---|---|---|
| | **Hounslow** | **Hounslow** | **England** | **Outer London** |
| **Number of:** | | | | |
| Children who became to subject of a CP plan | 253 | 317 | 63,830 | 5,570 |
| Ceased to be on a CP Plan | 316 | 254 | 65,200 | 5,410 |
| **Rate per 10,000 for:** | | | | |
| Children who became to subject of a CP plan | 38.4 | 48.2 | 52.8 | 43.2 |
| Ceased to be on a CP Plan | 48.0 | 38.6 | 53.9 | 42.1 |

**Looked after children as at the year-end**

- There were 296 looked after children (LAC) as at 31 March 2022 which was 41 more children than the previous year. Of the 296 LAC as at 31 March 2022, 123 (41.5%) were placed in residential care, this is higher than in the previous year (35%)
- Of the 255 LAC as of 31 March 2021, 6 children (2.0%%) were accommodated under Section 20 and under the age of 14 years.
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| Safeguarding Children Looked After (CLA) | 2021/22 | 2020/21 | 2019/20 | 2018/19 | 2017/18 |
|---|---|---|---|---|---|
| The number of CLA at the year end | 296 | 255 | 269 | 278 | 248 |
| Number of CLA in residential care | 123 | 91 | 89 | 91 | 66 |
| Number of CLA under police protection in LA accommodation | 0 | 0 | 0 | 0 | 0 |
| Number of CLA accommodated under Section 20 under the age of 14 | 6 | 9 | 16 | 5 | 18 |

**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 | 67.0 | 43.0 |
| 2021/22 | 296 | 45.0 | | |

**Children missing from care**

- The number of children reported missing from care in 2021/22 was 70 this shows an increase of 10 children compared to 2021/22 when it was 60.

| Missing Children | 2021/22 | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|---|
| Number of Missing Children<br><br>(episode in year) | 70 | 60 | 59 | 40 |
| Number of Missing Episodes<br><br>(total episodes in year) | 243 | 353 | 315 | 135 |
| 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 increased to 114 children during 2021/22, from 100 in the 12 months to 31 March 2021.

| Missing Children | 2021/22 | 2020/21 | 2019/20 | 2018/19 |
|---|---|---|---|---|
| Number of Missing Children | 114 | 100 | 109 | 155 |
| Number of Missing Episodes | 194 | 181 | 245 | 297 |

## 8) HSCB Targeted Priorities 2021/23

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.

### Priority 1 – Neglect

**Outcomes to be achieved**

**Outcome 1:** To secure collective commitment to addressing neglect across all partners agencies and to demonstrate effective leadership in driving the appropriate system, culture and process changes required.

**Outcome 2:** To improve awareness and understanding of neglect across the whole partnership. This includes a common understanding of neglect and thresholds for intervention.

**Outcome 3:** To improve the recognition, assessment and response to children and young people living in neglectful situation before statutory intervention is required including the appropriate use of assessment tools.

**Outcome 4:** To improve the effectiveness assessment and response to children and young people living in neglectful situations ones they are known to statutory services.

**Outcome 5:** To test and ensure the effectiveness of service provision

**Achievements in 2021/22**

Evidence of the following achievements is held within the Neglect Strategy and Implementation Plan.

- Completion of Neglect Audit with recommendations being embedded into the Neglect Strategy
- Quality of Care (QoC) Tool is listed in the induction pack for new social workers and students as mandatory training.
- Named GP Safeguarding Children covers neglect and an overview of the QoC tool in the Level 3 training
- Neglect included in the GP Bulletins with findings from the Neglect Audit

- Child Protection Chair role updated and expanded during re-configuration of the service to support scrutiny and challenge function.
- Children's Social Care Completion of the QoC assessment is now measurable following changes to LCS.
- Revision of Neglect Strategy completed to incorporate outcomes from national learning, good practice, and local quality assurance activity.
- Core Group Training to include multi-agency use of QoC ax.
- Neglect covered at the GP forum (presented by Named GP and Designated Nurse)
- Expectations in place for IRO's and CIN Reviewer to direct QoC to be used and monitored
- Neglect data for CP cases, QofC completion has been in place since January '22 and is shared with Team Managers weekly for monitoring.
- Specialist adolescent assessment created and piloted in June which included the neglect toolkit to provide clarity on what does not qualify as neglect in terms of adolescents and exploitation.

**Activity for 2022/23**

- Development of bespoke Neglect dataset
- All agency leads to provide assurance, including qualitative narrative and quantitative data on how services are monitoring neglect practice, assessment and use of QoC tool.
- Digitalisation Project to track and collate of agency completion of QfC at point of referral
- Quarterly reminders to workforce of Neglect strategy, assessment tools, guidance and training
- Reinstate higher-level neglect training
- Update Early Help Offer to recognise and support children prior to needing statutory intervention.
- Multi-agency chronologies using Chronolator to be introduced as part of the multi-agency assessment process.
- Single agency feedback from children and their families to support reviewing the effectiveness of neglect practice against outcomes for children and families.

**Priority 2 – Child Sexual Abuse**

**Outcomes to be achieved**

**Outcome 1:** To secure a collective commitment to recognising and safeguarding children from intrafamilial child sexual abuse (CSA) across all partners agencies and to demonstrate effective leadership in driving the appropriate system, culture and process changes required

**Outcome 2:** To increase public awareness of CSA

**Outcome 3:** To improve awareness and understanding of intrafamilial CSA across the whole partnership. This includes improved awareness and recognition of the risk of and abuse from intrafamilial CSA and the appropriate responses, interventions and investigations

**Outcome 4:** To improve the effectiveness of support, including appropriate support and interventions with a child or young person who has been sexually abused, their family, and for perpetrators.

**Outcome 5:** To test and ensure the effectiveness of service provision

## Achievements in 2021/22

### Multi Agency Audit Learning Review

As a response to the JTAI in February 2020 which considered how professionals worked together in CSA cases, the HSCP undertook a Child Sexual Abuse Multi-Agency Audit in October 2020, where the professional involvement with 10 children was considered in detail. A Learning Briefing was produced in 2021 which outlined the area of learning for local practice:

- Increasing awareness of CSA and ensuring that professionals 'Think the Unthinkable'.
- All professionals involved in this complex work should have access to expert advice, guidance and support to help manage the emotional impact.
- There is a lack of or misplaced professional confidence around working with CSA cases. Professionals need appropriate knowledge about perpetrators of sexual abuse to consider their ability to manipulate professionals and family members.
- When there are concerns that a child has sexually abused another child in the family, both the alleged perpetrator and victim need to be considered as children in their own right. Consideration should be given to whether the perpetrating child is being abused themselves. Each case should be considered singularly to assess the correct pathway to be taken, specifically, where the age of criminal responsibility has been reached.
- Professionals need to be curious about children's behaviour and identify other indicators that they may be a victim of sexual abuse and continually challenge and be curious about the source of children's distress.
- Children are likely to be more vulnerable to CSA if they are disabled, a young carer, have health needs, have suffered a significant bereavement, have witnessed domestic abuse at home, have a history of neglect or physical abuse, have a parent who was sexually abused in childhood, and/or who has mental health issues or learning needs. There is evidence that perpetrators can target vulnerable children because they may believe they are less likely to disclose the abuse or be believed if they do.

### Training and Workforce Development

- The partnership agreed to fund a range of CSA training to support practitioners learning and to improve practice. We have undertaken training for trainers and have a committed team of six facilitators delivering a course that covers the following areas:
    - Prevalence
    - Barriers to recognition
    - Help seeking behaviour in children
    - Sexually harmful behaviour in adults
    - Non abusing parent
    - Family dynamics

Online delivery began in October 2021 to avoid delay due to Covid restrictions. Feedback has been positive with people saying it is ‘an eye opener’, ‘up to date’ ‘covering areas they didn’t know’.

**Activity for 2022/23**

- Launch of the CSA Strategy and Implementation Plan
- CSA Task and Finish Group
- CSA Training for Managers
- Training including Traffic Light Tool (delivered by Brook), Sex Pressures and Pornography, Gender ID, and ‘Signs and Indicators Template’ (Sexual Abuse Centre for Excellence).

**Priority 3 – Vulnerable Children in Education**

**Achievements in 2021/2022**

- The Top 10 Most Vulnerable Group, chaired by the DCS, continued to meet, focusing on learning from cases, emerging trends and addressing complex system wide issues. The meeting is informed by the Vulnerability Index which matches school census data with a range of other data sources likely to offer some indication that a child might be vulnerable.

- The Education Service secured £915k Covid funding from the LA to support the most vulnerable pupils identified as needing a significant amount of catch-up support. For schools to access funding the LA have tasked HEP to coordinate school applications, ensuring meet set criteria and that schools return data to evidence of impact for audit purposes.

- Recruitment of a Home Education Coordinator, which has enabled the team to keep on top of the consistently challenging workload. Close monitoring of the issue continues, with oversight through the Children’s Improvement Board and Finance and Performance Board. The Front door, EHE and Education Welfare teams have established monitoring arrangements to maintain oversight of EHE children and young people considered most vulnerable and this together with close partnership working with SEND and Social Care, has enabled the team to fulfil its role as part of the safeguarding net. Along with agreement to recruit a dedicated Safeguarding Advisor on a fixed term basis, to support EHE and schools.

- The School Liaison Initiative (SLI) was launched in 2020 by Children Social Care (CSC) with the aim to strengthen the relationship between Schools and Children’s Social Care, focusing on prevention, responding earlier to low level support needs with the aim of reducing the demand to the Front door. All 77 School’s in Hounslow (Infant, Primary and Secondary) have been allocated a link social worker to discuss cases that the school want advice on. This does not supersede the referral process to the front door for safeguarding concerns, neither does it discuss cases open to CSC, it provides a platform to obtain advice on early help/low level concerns. It is the role of the linked social worker to give advice on thresholds and next steps on presented cases by schools.

**Activity for 2022/23**

- Workshop for Designated Safeguarding Leads and linked social workers to discuss the School Liaison Initiative, agree a way forward and provide structure.

- Provide schools with a support package tailored to the school's needs.

**Priority 4 – Children with Disabilities and SEN**

**Achievements in 2021/2022**

- Hounslow Integrated Care Partnership Board (Chaired by the Chief Executive) and having representation form NHS, primary care and the LA agreed in 2021 to establish a new ICP Workstream for Children with Disabilities, SEND and complex needs to provide a joint forum for transformation, joint working and development for services for children in this defined cohort. The Workstream is chaired by the Executive Director for Children's and Adults Services, with joint Senior Responsible Officer status with the Director of Commissioning/CCG Accountable Officer.

- Recruitment of a full-time 0-17 CWDSWT Manager and strengthened management arrangements with the appointment of a new Service Manager with responsibility for the social work element of the SEND service.

- Review of the workflow under the Chronically Sick and Disabled Persons Act (CSDPA) for children with disabilities who do not require an ongoing statutory social work intervention. This has lead to improved recording and ensuring that procedures in place are appropriate to need and to step up cases as required. Updated operational guidance has been produced and reporting has become more accurate.

- Robust monitoring systems in place for vulnerable groups with EHC Plans. For children who are looked after, annual reviews are scheduled where possible to coincide with Personal Education Plans to ensure there is alignment with targets and outcomes. LAC data (who is new into and out of care) is provided to SEN on a weekly basis.

- The Youth Offending Service (YOS) currently benefits from a full-time Speech and Language Therapy provision and as such, all young people entering the YOS in a statutory or early intervention capacity are screened for any presenting speech, language and communication needs and this information is used to design bespoke interventions based on the needs of the young person. Where previously unidentified/undiagnosed needs are present in children who are in formal education, the YOS Senior Leadership Team will liaise with both the School and the Local Authority SEN Team to share findings.

- The Preparing for Adulthood Protocol has been revised and shared at the ICP Sub-group children with disability, SEND and complex needs. The protocol summarises the statutory duties of SEND and Social Care for young people with EHC Plans and what young people and their families/carers can expect throughout their journey from year 9 (age 14) to 25 years of age. A review of post-16 pathways for young people with EHC plans was also completed to inform the development of a pathways for 3 cohorts of young people.

- Re-launch post-COVID of the successful internship programme in Partnership with West Thames College, Project Search, Hounslow Council and Kaleidoscope. Work is progressing to develop job coach training and an apprenticeship.

- An LGA 2-day external Peer Review of SEND services in May 2021 provided an analysis of current practice and is informing improvement activity.

- The Children's Home inspection of Westbrook Short Break and Resource Centre in December 2021 was outstanding across all areas noting that "Strong, child-centred leadership in the home helps children to make exceptional progress from their starting points." Regulation 44 reports completed by the independent visitor consistently highlight the high standard of care and person-centred planning that is in place for each child that attends Westbrook.

**Activity for 2022/2023**

- The outcome report of the February 2022 SEND Local Area review is not yet published however CWDSWT are working closely with partners to develop its improvement plan in response to the feedback received.

**9) Feltham YOI (FYOI)**

HMP Feltham YOI was subject to an unannounced inspection from 21st February to 4th March 2022, which was the first since being placed within the Urgent Notification (UN) process.

The inspection detailed signs of improvement and an impressive transformation, resulting in the prison being safer, happier and more productive; with a more confident staff team able to meet the often-complex needs and address the behaviour of what is, at times, a challenging group of children. Outcomes for children had improved in four healthy establishment areas:

- Safety – from poor to reasonably good
- Care - from poor to reasonably good
- Purposeful Activity – from poor to not sufficiently good
- Resettlement – from not sufficiently good to reasonably good.

**Achievements in 2021/22**

- The Dedicated Social Work (DSW) Team and the Resettlement department have continued to work in partnership to improve the LAC review process to ensure all reviews are multi-agency. The process now ensures that the Resettlement team organise reviews; ensuring they are combined with remand/sentencing planning meetings. This better ensures information on these areas of need are gathered and reported in a more structured format. The DSW team continue to encourage and promote multi-agency and partnership way of working to present the holistic views of each of young person.

- The DSW team have been running a dedicated social work and safeguarding workshop for all new staff since 2020 which enhances awareness and knowledge of the role of the team. Within this year, this has also been rolled out among existing staff. To further ensure all employed staff benefit from this training, the training

sessions are available to both operational and non-operational staff. The team have completed 15 workshops between April 2021- March 2022.

- The continued efforts from the LADO service for FYOI to promote the use of Body Worn Cameras (BWC) has resulted in an increase in the use of BWC by Officers during interactions with the young people. This is an excellent step forward both for safeguarding the young people and the Officers. The use of BWC has also evidenced some positive practice shown by Officers during their interaction with the young people.

- Revision of LADO Terms of Reference to reflect times when covid may impact on practice.
- Completion of the Section 11 audit for assurance to support with the UN Action Plan.
- Monthly Safety Overview Reports.
- Completion of the Child Protection Medical Pathway.
- Completion of the Child Sexual Abuse Pathway.
- Completion of the Health Action Plan

**Activity for 2022/23**

- Revise LADO referral form to ensure all relevant information and risk assessments are included.
- Provide LADO refresher training to colleagues at FYOI Safeguards.
- Inclusion of a review of supporting clinical information by the Designated Nurse for the monthly audits on restraint practices (coordinated by the LADO)
- Safeguarding Advocacy Protocol (Barnardo's)

**10) Learning and Improvement**

**Local Child Safeguarding Practice Reviews**

**Family X**

The final report, published in November 2021, highlighted the challenges professionals often face when dealing with the neglect of children. One of the most important findings of the review was the vital importance of chronologies, especially in cases of chronic neglect.

It also highlighted the importance of maintaining professional curiosity to ensure that relevant information is collated, assessed, and reviewed is to ensure children are to be protected from neglect and significant harm. The recommendations from the review have been incorporated into the Neglect Action Plan.

**Child A**

The final report on the review of this case, which was one of long-term neglect and absence from education, is due to be published in Q1 of 2022/23 with an accompanying 7-Minute Briefing. Recommendations will be incorporated into the Neglect Action Plan.

**Rapid Reviews**

In the last year, a serious incident notified to the DfE and National Panel by Kent County Council did not result in the decision to conduct an LSCPR. Hounslow had limited involvement with the case as the incident occurred only a few months after the young person moved to the borough.

**Case Learning Discussions**

The Cases Sub-Group ensures that, at a strategic level on behalf of the Safeguarding Partners and the HSCP, organisational lessons are learnt, and changes are implemented, from the review of local and national serious cases of child abuse, neglect, or death, to prevent future incidents of serious child abuse or death.

Themes identified for discussion in 2021/22 were:

- Appropriate and timely professional escalation
- Consideration of wider factors
- Effectiveness of Protective Plans
- Effectiveness and impact of the multi-agency network around the family
- Effectiveness of challenge and escalation
- Correct information sharing between agencies
- Wider learning around physical abuse and Non-Accidental Injury
- Timeliness of strategy meetings and appropriate professional attendance.

**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.*

The Executive Partnership Board is now well established, and the effectiveness of entire partnership is governed by strategic members of this board.

**Strategic Assurance, Effectiveness, and Impact Monitoring Framework**

***Outcome 1: Statutory safeguarding partners are actively involved in strategic planning and implementation***

| **Progress at 31st March 2022** | | **Progress at 15th November 2022** | |
|---|---|---|---|
| The safeguarding partners have agreed a strategic safeguarding plan which includes agreed outcomes in line with national guidelines and recent research. | | Evidence: HSCP priorities were agreed, a plan development which was published on the partnership website. Sub-Group workplans are linked to the Strategic Plan. | |
| Senior representatives with decision making and influencing authority are engaged in relevant meetings, sub-groups, and working groups to support delivery of the strategic plan. | | Action for 2022/23: Inclusion of education representative on the Partnership Board.<br><br>At the time of writing this report an education representative has been identified. | |

| | | | |
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| The safeguarding partners are assured that the HSCP works effectively alongside other partnerships such as the HSAB; CSPB; YCMB and H&WBB. | | Action for 2022/23: Re-establish purpose and focus of the Strategic Chairs meeting with all partnership buy in.<br><br>At the time of writing this report it was agreed that the Strategic Chairs function will be incorporated in the Executive Board which is now well established. | |
| There are reporting, scrutiny, and challenge processes in place to provide assurance and impact of effectiveness. | | Evidence: Mostly in place but reviewing outcomes and evidence is missing. | |
| The safeguarding partners have a clear line of sight of operational practice and are clear how the work of the HSCP is improving the multi-agency system. | | Evidence: Good line of sight through reviews and audits but need to close the loop about improvement and impact on practice. | |
| The safeguarding partners act effectively as a leadership group to provide scrutiny and challenge to the multi-agency safeguarding system. | | Evidence: Recent improvements with better use of Executive evidenced in Minutes, action logs and agendas, triangulated with items reported in from sub-groups and other areas of the partnership. | |
| As the fourth statutory safeguarding partner, schools are actively engaged in the work of the HSCP and taking responsibility for driving the local and national safeguarding agenda across the network of schools and education provisions. | | Evidence: Engagement at Heads Breakfast briefings, involvement in audit (neglect 2021) and consultation activity, re-election of secondary reps, ongoing engagement with West Thames College, ongoing programme of safeguarding audit with good take up.<br><br>Actions for 2022/23: 1) Work with DSLs to take a leadership role for safeguarding as a network in their own right with support of the HSCP, 2) Agree how schools will be represented at the Executive Board.<br><br>At the time of writing the report an education representative has been identified to attend Executive Board | |
| | | | |
| The HSCP produces and publishes an annual report and statement of assurance that evidences the impact of the activity undertaken in the previous year. | | Evidence: Annual report focus has improved on impact and assurance but missing clear statement of assurance supported by evidence/<br>Action for 2022/23: Implement process to ensure inclusion of assurance statement from Independent Advisor and Executive Board. | |

***Outcome 2: Statutory safeguarding partners and all relevant agencies are actively involved in and take responsibility for safeguarding children and the work of the HSCP***

| | | | |
|---|---|---|---|
| The wider HSCP including all relevant agencies and the private and business sector, informed of, and actively are engaged with the partnership arrangements and strategic safeguarding plan. | | Evidence: Good engagement from wide range of agencies but missing private sector and VCS. | |
| The wider partnership agencies are informed of and adhering to national guidelines regarding issues impacting on safeguarding children. | | Evidence: Mostly assured but cannot easily evidence this outside of audit and case reviews.<br>Action for 2022/23: Assurance to be gained through Section 11 audit to be rolled out in January 2022.<br><br>At the time of writing this report the Section 11 audits have been completed with a very good return from all Schools. | |
| The wider HSCP including all relevant agencies are adhering to information sharing and staff training protocols. | | Evidence: Operationally information sharing is robust. Evidence is anecdotal at a partnership level. Training protocols and data are not shared. Have MA training data.<br>Action for 2022/23: 1) Tracking of HSCP Escalation Policy 2) Report to evidence multi-agency training attendance and joint training roll-out. | |
| All agencies are engaged with identifying and reviewing safeguarding priorities and sharing concerns up to and down from Safeguarding partners. | | Evidence: All agencies actively engaged with identifying priorities with discussion and activity through partnership board and sub-groups. Escalation of concerns up is good, more to do to cascade concerns down to operational staff and embed improvements. | |
| Elected members are informed of and are actively involved in the work of the HSCP and the safeguarding children agenda. | | Evidence: Active engagement from Lead member, regular meetings with HSCP Service Manager, Advisor and Executive Director, twice yearly meeting with the Leader and Lead member for Hounslow Safeguarding Adults Board. | |

### *Outcome 3: Children, young people, and families are aware of and involved with plans for safeguarding children*

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| Children and young people's views are considered in the development, implementation and review of the safeguarding plan and operational service delivery. | | Evidence: Included in some Quality Assurance and review work and schools demonstrate this well through the safeguarding audit. More to be done on consulting on partnership priorities and initiatives and agencies reporting on how children and young people are impacting and shaping service delivery.<br><br>Actions for 2022/23: Include in strategic plan and sub-group workplans. | |

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| Strategies are in place to ensure children and young people know they have a right to be safeguarded. | | Evidence: Plan presented to the HSCP Board, agreed and published on website.<br>Action for 2022/23: Exploration of HSCP comms campaign in 2022/23 providing budget available. | |
| Children and young people are able to (where appropriate) contribute their views in aspects of the HSCP and operational practice. | | Evidence: Children, young people and families are consulted in all HSCP audit, review and where appropriate strategy development.<br><br>Actions for 2022/23: Board discussion on single agencies consulting with children, young people and families in operational service delivery. | |
| Young people play a role in assessing their safeguarding concerns in their transition to adult services. | | There is no evidence available, Actions have been identified at an Executive meeting on 09.08.21 and will progress through HSCP Board.<br>Action for 202/23: Youth Council report to be presented at Q1 Board.<br><br>At the time of writing this report audit activity took place which highlighted good interface between Children's Social Care and Adult Services. Further audit will be completed in 2022/23 to consider early preparation of transition for young people in Children's Social Care. | |

***Outcome 4: Appropriate quality assurance procedures are in place for data collection, audit, and information sharing with the HSCP***

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| Mechanisms and processes are in place for the safeguarding partners to collect and analyse relevant data to support assurance of effectiveness. | | Action for 2022/23: Executive to consider if the Safeguarding Health Outcomes Framework (SHOF) can be used to provide quarterly data and data analysis.<br><br>At the time of writing this report SHOF data has been shared with HSCP. Process of analysing and use of data in the HSCP to be actioned in 2022/23 | |
| Wider partnership agencies including relevant agencies are undertaking and sharing their own audits and data linked to safeguarding children. | | Action for 2022/23: Safeguarding Effectiveness Sub-Group to work with agencies to identify processes to share single agency data and audits and develop a multi-agency dataset.<br><br>At the time of writing this report a template has been created for all agencies to report on their own quality assurance activity through the year. Standard agenda item at Safeguarding Effectiveness Sub-Group. | |

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| All relevant data, quality assurance and learning activity from across the partnership is used to review the impact and effectiveness of safeguarding outcomes. | | Evidence: Quality Assurance and learning activity from HSCP is used but more evidence of impact needed.<br><br>Actions for 2022/23: Safeguarding Effectiveness Sub-Group to work with agencies to identify processes to share single agency data and audits and develop a multi-agency dataset. | |
| All relevant data, quality assurance and learning activity shared with the partnership and used to inform an assessment of gaps in data, identification of priorities, and future strategic safeguarding plans. | | There is no evidence available. Able to use what is generated by the HSCP but not from single agency.<br>Action for 2022/23: Add to the Safeguarding Effectiveness Sub-Group workplan.<br><br>At the time of writing the report partners have provided their single agency data sets. Further work will be undertaken in 2022/23 to develop a HSCP multi-agency data set. | |

***Outcome 5: There is a process for identifying and implementing learning from local and national case reviews***

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| All safeguarding partners know the criteria and process for referring cases which meet the threshold for local or national review. | | Evidence: Demonstrated through RR and case learning discussion and process. | |
| Case reviews are properly funded to prioritise and respond to learning and agencies re proactively responding in real-time. | | Evidence: Reviews are good quality, focused and include all identified and important individuals and agencies. | |
| Learning from reviews being cascaded to all professionals and is used to improve outcomes | | Evidence: Some tangible evidence but cannot be tracked through data. Mostly tracked through audit and assurance papers.<br><br>Actions for 2022/23: 1) Report from HSCP Training to outline agency attendance. 2) Assurance report from agencies to outline how learning from reviews are used, including evidence of improved outcomes.<br><br>At the time of writing this report evidence can be found in SE Subgroup minutes, including 7-minute briefings. | |
| There is evidence that learning from case reviews is included in training, policy and practice for safeguarding. | | Evidence: Neglect strategy and training, Adolescent Safeguarding Strategy and training, CSA Strategy and training, revision of escalation policy. | |

***Outcome 6: There is an active program of multiagency safeguarding children training***

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| There is a process for identifying, providing, and evaluating multi-agency training needs for all safeguarding partners to respond to safeguarding children. | | Evidence: Delivered via Training and Development Manager. Course programme is reflective of multi-agency training need. Reported in HSCP Annual Activity Report. Action for 2022/23: Include evaluation of training in Training and Development Manager workplan. | |
| Multi-agency training is responsive to the local safeguarding strategic plan, data analysis, emerging local and national need and up to date research findings and national policy. | | Evidence: Evidence gathered via training take up, reporting and course content. | |
| The take up and use of single agency and multi-agency safeguarding training is reviewed by all partnership agencies. | | Evidence: Multi-agency training reviewed as part of the Safeguarding Effectiveness Subgroup.<br><br>Actions for 2022/23: Incorporate into Safeguarding Effectiveness training workplan and standard assurance checking. | |
| All agencies are assessing the impact of safeguarding training on practice, improving outcomes and informing future training needs. | | Evidence: Training report presented at the Safeguarding Effectiveness Sub-Group. presented at Feb 22 SE Subgroup. Report from HSCP Training due April '22 which will<br><br>Actions for 2022/23: Assurance report from agencies to outline how learning from reviews are used, including evidence of improved outcomes. Standard agenda item for Safeguarding Effectiveness Sub-Group. | |

***Outcome 7: The HSCP is properly resourced by the statutory safeguarding partners to meet the expectations of WT18, the Wood Review 2021 and deliver its strategic safeguarding plan and respond to local need.***

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| Equitable and proportionate level of funding to support the local arrangements. | | No evidence available. Action for 2022/23: Financial position budget report to be discussed at Executive.<br><br>The Mayor's Office for Policing and Crime agree the funding for police. This is not locally managed and contributions are the same for all London Boroughs. | |
| Multi-agency training is responsive to the local safeguarding strategic plan, data analysis, emerging local and national need and up to date research findings and national policy. | | Evidence: Evidence gathered via training take up, reporting and course content. | |

**Multi-Agency Themed Audits**

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. Recommendations from all Audit activity feed into continuous service improvement work and learning is shared across the Partnership.

The Partnership undertook a multi-agency audit in relation to neglect in Hounslow as part of its work on the priority area. It was the third full audit and was commissioned to take stock of the effectiveness of the Neglect strategy and to have a focus on outcomes for children subject to neglect. Recommendations from the audit report have ben embedded into the Neglect Strategy.

The Partnership also undertook a multi-agency case audit to consider the referrals received by the Hounslow Children's Social Care Front Door by partner agencies where the decision has been made not to progress to assessment. The audit considered timeliness, quality, thresholds, decision making and communication. The audit identified areas of good practice and areas for development or areas of concern. A report will be presented in early 2022/2023 to the HSCP Executive Board and Partnership Board, setting out findings and recommendations.

The annual Education Safeguarding Self-Assessment audit commenced in February 2022 and will be reported on in the 2022/2023 Annual Report.

**Quality Assurance and learning activity planned for 2022/23:**

- Section 11 Audits by Education
- Single Agency Neglect audits to inform Neglect implementation plan
- Impact of Training

## 12) Private Fostering

As referenced in section 5 the partnership has not received any information in relation to Private Fostering in Hounslow for the second year running. This is a significant gap which needs to be addressed urgently.

## 13) Voice of the Child

There have been assurances from single agencies through the Safeguarding Effectiveness Sub-Group that feedback is gathered and used to inform practice. Within Children's Social Care feedback from children in gathered at reviews where appropriate depending on the situation, during monthly audits, conferences and the ASYE Programme.

A Young Researcher's project in December 2021 saw 2,072 of the boroughs' children and young people take part in an exercise which identified themes of priority for change which were; 1. Education, 2. Mental Health, 3. Streets & Transport, 4. Safety and Crime. The top 4 priorities for young people were; 'Make it safer', 'Make it cleaner', 'Reduce poverty' and 'Have more and better things to do'. The research will help inform ongoing work with partner agencies to improve services.

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.

## 14) Conclusion

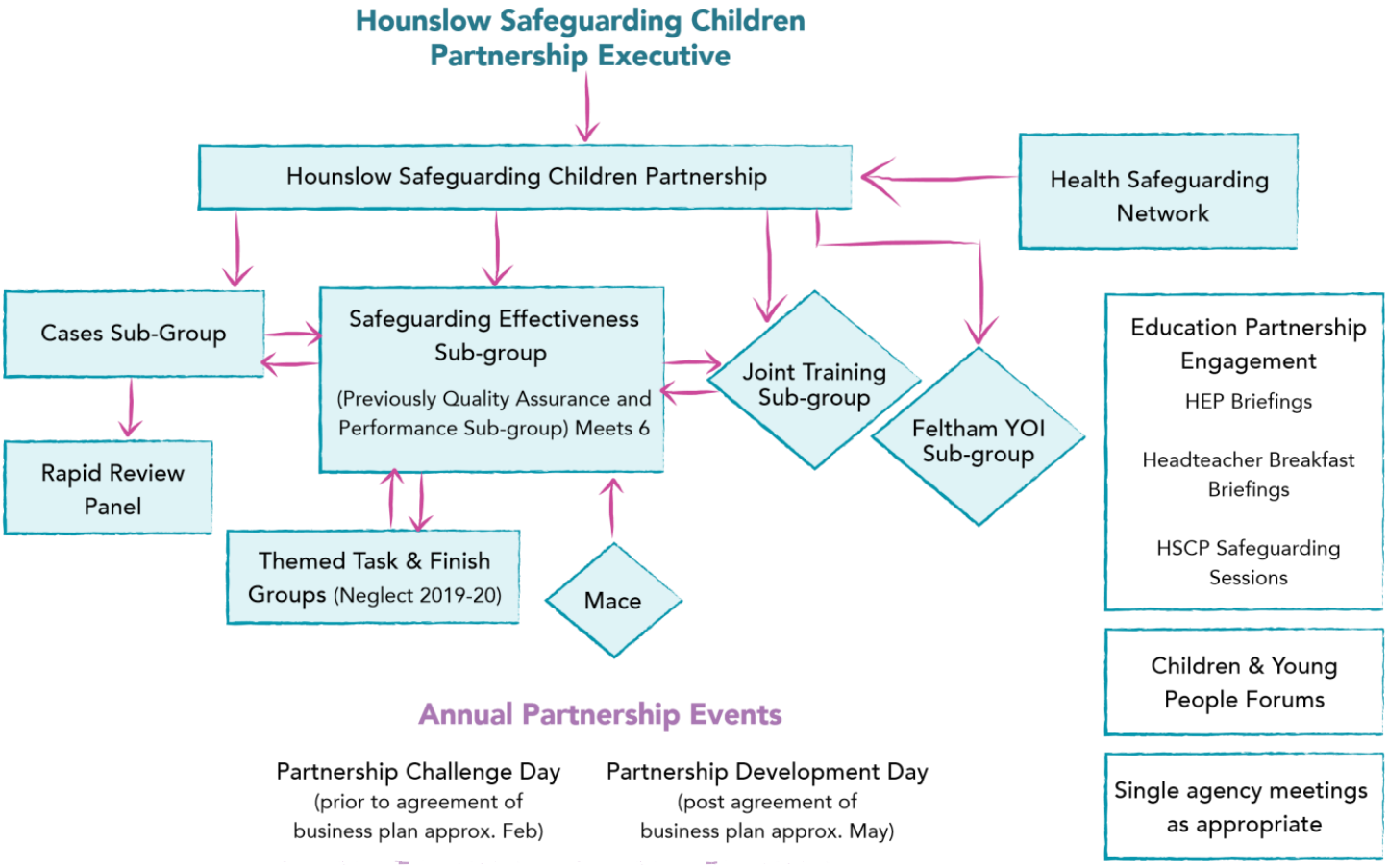
Based on the Strategic Assurance, Effectiveness, and Impact Monitoring Framework outlined in section 10 of this report, it can be concluded that the Partnership is functioning well with evidence of significant progress and assurances being provided.

Partnership efforts have predominantly been focused on the complex themed priorities of Neglect and Child Sexual Abuse and work will continue in 2022/23 with priority focuses on producing a multi-agency neglect dataset, introducing multi-agency chronologies as part of the assessment process, and launching the CSA Strategy and Implementation Plan.

As a result of close monitoring by the Executive, there has been progress in a previously recognised weak area of the partnership regarding the sharing of analysed data and single agency feedback audits. This is integral to the partnership in 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.

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. 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.

**Appendix A – HSCP Structure**



**Appendix B - HSCP Board Membership and Attendance April 2021 - March 2022**

| Role | Representing | Partnership Role | Attendance |
|---|---|---|---|
| Independent Advisor | Hounslow Safeguarding Children Partnership | - | 5/5 |
| Business Manager | Hounslow Safeguarding Children Partnership | Advisor | 4/5 |
| Training and Development Manager | Hounslow Safeguarding Children Partnership | Advisor | 4/5 |
| 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 | 3/5 |
| **Children's Social Care (Statutory Safeguarding Partner)** | | | |
| Interim Assistant Director | Children's Safeguarding and Specialist Services | Executive and Partnership Member | 3/5 |
| Head of Safeguarding & Quality Assurance | Children's Safeguarding and Specialist Services | Partnership Member | 3/5 |
| Head of Adolescent Services | Children's Safeguarding and Specialist Services | Partnership Member | 3/5 |
| **Health (Statutory Safeguarding Partner)** | | | |
| Associate Director for Safeguarding Children | North West London CCG | Executive and Partnership Member | 0/5 |
| Designated Doctor for Safeguarding Children | North West London CCG | Advisor | 3/5 |
| Designated Nurse for Safeguarding Children | North West London CCG | Advisor | 4/5 |

| | | | |
|---|---|---|---|
| Consultant Midwife for Public Health & Safeguarding | Chelsea & Westminster Hospital | Partnership Member | 5/5 |
| 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 |
| Director of Safeguarding Children & Adults | West London NHS Trust | Partnership Member | 4/5 |
| Named Nurse for Safeguarding Children | West London NHS Trust | Partnership Member | 2/5 |
| Service Manager | Arc / Hype Drug and alcohol Service | Partnership Member | 3/5 |
| Borough Commander | London Ambulance Service | Partnership Member | 0/5 |
| Detective Superintendent | West Area BCU | Executive and Partnership Member | 5/5 |
| **Local Authority Education (Relevant Agency)** | | | |
| Interim Assistant Director for Special Educational Needs and Disability | Education | Partnership Member | 2/5 |
| Interim Assistant Director Education & Skills | Education | Partnership Member | 4/5 |
| **LB Hounslow (Relevant Agency)** | | | |
| Head of Community Safety | Community Safety Team | Partnership Member | 3/5 |
| Assistant Director Homelessness, Independence and Preventative Services | Housing | Partnership Member | 5/5 |
| Children's Commissioning Manager | Public Health | Partnership Member | 4/5 |
| **Education (Relevant Agency)1** | | | |
| Nominated Representative | Alternative Provision and Special Schools | Partnership Member | 5/5 |
| Nominated Representative | West Thames College | Partnership Member | 1/5 |
| Nominated Representative | Secondary Schools | Partnership Member | 3/5 |

| | | | |
|---|---|---|---|
| Nominated Representative | Primary Schools | Partnership Member | 4/5 |
| Invited Representative | Independent Schools | Partnership Member | 1/5 |
| **Secure Estate and Probation Service (Relevant Agency)** | | | |
| Head of Safeguards | Feltham Young Offenders Institute | Partnership Member | 4/5 |
| Head of Service | Hounslow, Kingston and Richmond, National Probation Service | Partnership Member | 0/5 |
| 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 | 1/5 |

**Appendix C – 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 |
| 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
WTSC - Working Together to Safeguard Children
YCS - Youth Custody Service