HSCB

Hounslow Safeguarding Children Board

Hounslow Safeguarding Children Board

Annual Report

2017-18

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1) Foreword from the Chair

This annual report covers the period 1st April 2017 to 31st March 2018 and is the second annual report to cover the period since my appointment as independent chair to the Safeguarding Children Board in October 2016. The annual report is the opportunity for agencies working to safeguard children to report and reflect on what has been achieved in the previous twelve months as well as on the challenges faced in ensuring safeguarding processes in Hounslow are as robust as they can be. The annual report should be read in conjunction with the board's rolling Business Plan which updates the board's objectives for the next 3 years.

A key function of the board is to provide 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. A key role for the board has been to monitor the action plan based on the recommendations from the Ofsted Joint Targeted Area Inspection (JTAI) which looked at provision for children living in households experiencing domestic violence as well as action plans from the external inspections of Feltham Young Offenders Institution (FYOI). The board commissioned external audits of the Multi Agency Safeguarding Hub (MASH) and control and restraint in FYOI.

Given the JTAI recommendation that agencies should provide the board with improved performance information, this year has seen a determined push to develop an enhanced data set to help the board prioritise where to target its interventions. Data remains a challenge for agencies and is still very much work in progress. The board has received regular reports on the progress of improvements to the MASH resulting from both the JTAI and the external audit commissioned by the board. The issue of adequate health staff resources in the MASH to enable timely health checks on families remains an unresolved challenge as is managing the high volume of contacts presenting at the 'front door'. Another ongoing challenge is the level of partnership resourcing of the board with the council providing the bulk of the funding although other agencies do contribute in kind through the allocation of staff to board sub-groups and other initiatives.

Other key areas that the board has concentrated on during the year have been the development and roll-out of the multi-agency neglect strategy including the use of a neglect assessment tool for practitioners as well as base-lining the early help and intervention services offered by all the safeguarding partners. I am pleased that the work on early help is now being taken forward at pace by the Early Help Strategic Group with the board continuing to have a role in assurance.

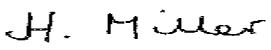
In order to achieve the necessary levels of assurance for the safeguarding of children in Hounslow and to help inform the board work plan, a second challenge event was held in March 2018 where agencies presented their key good practice developments and identified their key challenges. Individual agency contributions were scrutinised by fellow board members. These findings will feed into an independently facilitated development and business planning session to be held in May 2018 where board members will collectively assess board performance over the previous twelve months and set objectives for the next three years.

The board continues to have committed membership from partner agencies on its various sub-groups. These sub-groups are the heart or engine room of the board and ensure the successful implementation of the board's policies and assurance role. Chairing both the safeguarding adults board and the safeguarding children board, I am uniquely placed to seek assurance that service delivery from both adult and children services across the various agencies are sufficiently "joined up" so there is a family focus. Both boards have now agreed in their business plans to focus on the adult/children interface recognising that vulnerable people may have children who are in need.

A number of interactive seminars/workshops have been held this year open to frontline staff and managers from children and adult partner agencies as well as interested participants from the voluntary and community sectors. Topics have included domestic violence and forced marriage and other honour based violence, the mental capacity act, familial abuse and neglect. Going forward this programme will be sponsored by the joint training sub-group covering both the adult and children safeguarding boards.

The Safeguarding Children's Board does not operate in isolation from other partnership structures within Hounslow as its agenda in safeguarding children has key overlaps with the Safeguarding Adults Board, the Community Safety Partnership Board and the Health and Wellbeing Board. It is essential that strategy, policy and protocols as well as operational service delivery are "joined up" to ensure that vulnerable children and adults do not fall through any gap in provision. In order to facilitate this joined up agenda, the chairs and/or key strategic officers of these key partnership boards have met during the year to ensure coordination of effort and avoidance of duplication. The Community Safety Partnership leads on domestic violence, harmful practices e g female genital mutilation and modern slavery. It has been agreed that a report on each of these areas will be presented to both the safeguarding adults and safeguarding children boards each year. This annual report will again be presented to the autumn meetings of both the Health and Wellbeing Board and the Children's Scrutiny Panel.

Hannah Miller OBE,



Independent Chair Hounslow Safeguarding Children Board

2) Introduction

This report is the second annual review of the effectiveness of local safeguarding arrangements and the Hounslow Local Safeguarding Children Board (HSCB) under the current independent Chair. The report sets out the progress made by the HSCB and covers the period of 1st April 2017 to March 2018.

Keeping children safe is a shared partnership responsibility with each agency fulfilling their role and responsibilities to promote the welfare and safeguarding children in Hounslow. Effective partnership working requires each agency to commit resources to deliver strategic and operational priorities under Working Together to Safeguarding Children guidance, pan London child safeguarding procedures and local protocols and guidance.

In addition to the legal framework that an LSCB operates within, Hounslow's governance and scrutiny structures and local context for our children this report outlines the progress the HSCB has made in relation to its 2016-18 business plan which focussing on:

1. Safeguarding Children from Sexual Abuse
2. Harmful Practices
3. Protecting Children from Neglect
4. Safeguarding Children with Specific Vulnerabilities

The evidence has been collected from the work of the Board, its sub-groups, individual agency reports and HSCB training evaluation. There is also learning from multi-agency case reviews and audits, single agency audits, as well as assurance and monitoring activities.

3) Hounslow's Context

Population

Hounslow is the 9th largest London Borough (out of 33) in terms of geographical area and current estimates show Hounslow to be 19th largest by population (269,100). The total population of Hounslow is projected to grow by approximately 2,000 per year; the population aged 0-18 is expected to grow by approximately 700 per year. This growth in population is projected to decline looking further ahead. By 2028 growth is expected to be 1,000 per year for all ages and the population of 0-18-year olds is expected to decline by approximately 400 per year.

The ONS population projection for Hounslow for 2018 showed that the population age 0 to 18 years is approximately 67,517 and makes up 24.8% of the total population. This proportion is similar to the London average (23.7%).

Revised projections show that in 2018, the size of the 0-4 years age group is expected to be 20,371 (7.5% of the population), in 2021 is expected to be 19,909 (7.2% of the population) and in 2026 is expected to be 18,542 (6.5% of the population). Overcrowding, where the household has one fewer room than required, was the same in Hounslow in 2011 (22%) as in London. The wards with the most overcrowding were in Hounslow Central (36%) and Hounslow Heath (34%) and the least overcrowding in Hounslow South (13%) and Chiswick Riverside (13%).

Of the 95,000 households in Hounslow, 5.5% had dependent children living in the household, but no adults in current employment. This is 16% of the 32,800 households in Hounslow where there were dependent children.

Ethnicity, Language and Religion

The proportion of the population in 2011 aged 0-18 years by ethnic group (where the ethnic group is more than 10% of the 0-18 population):

1. White British (28%)

2. Indian or Indian British (16%)
3. Other White (12%)
4. Other Asian (11%)

At the time of the Census, Hounslow residents that identified as Christian ranked the largest at 42%, followed by those that identify as having no religion at 16%, Muslims at 14% and Hindus at 10%.

The languages spoken in Hounslow are reflective of its population profile. After English, the two most common languages spoken are Punjabi and Polish.

Child Poverty and Inequalities

The latest Indices of Deprivation carried out in 2015 by the Ministry of Housing, Communities & Local Government showed the proportion of children aged 0-15 years living in income deprived households is lower in Hounslow (22%) than in London (24%). The highest rates of child poverty are seen in the wards of Brentford (31%), Hanworth (30%), and Heston West (30%) with the lowest rate observed in Hounslow South (9%), lower than the England average at 19%.

4) LSCB's Legal Context and Developments

In May 2016, the Department for Education (DfE) published the Wood Review about the role that LSCBs play in protecting and safeguarding children. The Children and Social Work Act 2017 abolished Local Safeguarding Boards under the Children Act 2004 to allow more flexible local arrangements for safeguarding children. There will be further changes to Working Together (2015) and revised guidance was available for consultation in November 2017 to come into effect in 2018. The guidance will cover arrangements to undertake practice reviews into child deaths and serious injuries and the management of the Child Death Overview Panel (CDOP).

Section 16 of the *Children and Social Work Act 2017* states that the Safeguarding partners for a local authority area in England must make arrangements for:

a) the safeguarding partners, and

b) any relevant agencies that they consider appropriate, to work together in exercising their functions, so far as the functions are exercised for the purpose of safeguarding and promoting the welfare of children in the area. The arrangements must include arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area.

Each Board partner retains their own existing line of accountability for safeguarding. HSCB Board members include representatives from:

- Social care
- Police
- Health Economy, including Adult Mental
- Health
- Schools
- National Probation/Community Rehabilitation
- Company
- Legal Services
- Voluntary and Community Sector
- Commissioned providers

The specific responsibilities of the HSCB to safeguard and promote the welfare of children include the following:

- Raising awareness that children at risk of neglect and abuse is everyone's business;
- Seeking assurance that there is information and signposting to early help services to prevent issues that can be resolved at a non-statutory level escalating to statutory interventions;
- Promoting effective partnership working to refer, assess and make plans to keep children safe;
- Facilitating training about how to identify, refer and assess neglect and different forms of child abuse;
- Setting expectations that employers comply with the standards under S.11 in the Children Act 2004, and commensurate duties under S.175 of the Education Act 2002 for schools, which covers access to staff training and development, and safe employment procedures;
- Seeking assurance that the multi-agency child protection planning processes are working effectively and take action where needed.

HSCB Structure

Last year the HSCB held five Board meetings, one Challenge Day session, one Business Planning session and quarterly sub-group meetings in a 12-month cycle. The HSCB has also facilitated three Strategic Chairs Meetings with Chairs and representatives from each of the key strategic boards and held four Joint Targeted Area Inspection (JTAI) Action Plan monitoring meetings. *See Appendices A and B*.

5) Governance & Accountability

Under current arrangements and to provide effective scrutiny, LSCBs should be independent and should not be subordinate to, nor subsumed within, other local structures. The Chair should be independent of local services and have relevant experience in child services.

It is the role of the Chief Executive of Hounslow Council to appoint or remove the HSCB Chair with the agreement of a panel including HSCB partners and lay members. The Chief Executive, drawing on other HSCB partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the HSCB.

The HSCB Chair works closely with all partners and particularly with the Director of Children's Specialist Services. Regular Safeguarding meetings have taken place between the Chair of the HSCB, Chief Executive, Executive Director of Children's, Health and Adults' Services and Director of Children's Specialist Services. These meetings have continued to ensure that strategic and political leaders are aware of all relevant findings and developments and as such, governance and accountability are strengthened through clear and regular lines of communication.

Scrutiny of HSCB Annual Report 2016 -17

The annual report for the 2016-17 year was written to comprehensively reflect the work undertaken for the year and approved by the Board in September 2017. It was disseminated to all Board partners and published on the Boards bespoke website. For the second year in a row the Chair of the Board took the Annual Report through a further governance and scrutiny process, by presenting the report to the Health and Wellbeing Board in October 2017 and later to the Children and Young People Scrutiny Panel in December 2017. The commitment to invite outside scrutiny from strategic partners will continue, with this report being made available for discussion and challenge at the same panels in October 2018. Aside of the annual reports, the independent Chair regularly attends and presents the work of the HSCB at the Health and Well-being Board and Adult Safeguarding Board and provides feedback to the HSCB in turn.

Governance of Partners Reporting to the Board

Within the last year, annual reporting cycles for partner agencies have become a part of the Boards forward planning agenda and are regularly included in the Board meetings for information and challenge. Annual Reports, which have been considered during the year, include:

- Private Fostering Annual Report 2016-17
- Children Missing Education Annual Report 2016-17
- Child Sexual Exploitation & Missing Children Annual Report 2016-17
- Child Protection Annual Report 2016-17
- Corporate Parenting Annual Report 2016-17
- LADO Annual Report 2016-17
- CCG Annual Report 2016-17
- NHS London Region Annual Report 2016-17

Outside of its themed priority areas, within the last year, the Board has been sighted on and commented on the Community Safety Strategy 2017-20, Adults Mental Health engaging with Child Protection, scoping of the Early Help position across all partner agencies, and safeguarding arrangements within CAMHS. Further information about these reports will be addressed throughout the report.

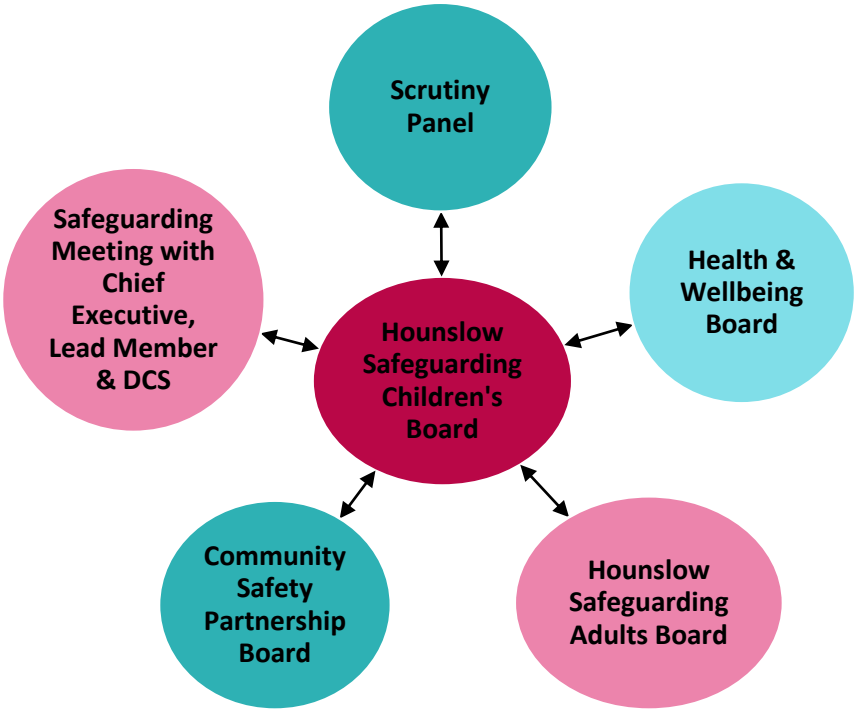
6) Links with Strategic Boards

The HSCB has continued to develop links with its strategic partnerships to determine lines of reporting and responsibility and to ensure that the Boards priorities are understood and supported by other strategically led activity. The Chair continued the momentum set by the previous Chair in 2016 and convened a meeting of the Chairs of the strategic Boards in Hounslow in July 2017. The primary focus has been to identify the strategies they hold responsibility for, including clarity on lead roles for targeted areas of work and identify opportunities for the HSCB to provide oversight and challenge from the perspective of the child safeguarding agenda.

Initially the HSCB had largely driven the agenda for the meetings and has supported its function however there has been increasing commitment from all of the Chairs of the strategic partnership and the operational staff that support the joint work. Meetings are now clearly owned by each Board and their agenda represented. The meetings have mapped areas of responsibility and feedback from each of the strategic Boards which is now a standard item on each Board agenda to ensure these links are not lost.

Scoping exercises have been undertaken to identify synergies and links primarily between with the two Safeguarding Boards and the Community Safety Partnership Board. The meeting has considered the roles of each of the sub-groups underneath the strategic boards to explore if there were opportunities to streamline the groups making information sharing and tasking more focused and SMART. Joint workshops and seminars are key projects which have taken place over the last year and a forward plan programme has been developed for the year ahead.

The meeting is convened quarterly and it is intended that the meeting will be formalised to be recognised as an instrumental forum in which to ensure solid strategic work and information sharing takes place between all the Boards.



7) Budget and Resourcing

The Board has prioritised improving its budget in 2017-18 and as forecasted in last year's annual report; it is in a stronger position. This has largely been achieved by the Board's self-sufficient approach and considerably limiting its expenditure on commissioning external trainers to deliver multi-agency training and instead utilising expertise available to deliver key courses and undertaking much of the quality assurance programme through the Business Management function of the Board. The HSCB has externally commissioned two audits one in the MASH and one reviewing the use of Control and Restraining in Feltham YOI.

These measures have contributed to a healthier financial position, the approach has at times been resource intensive in relation to the time commitment from Board staff to achieve required outcomes and to deliver the Board priorities.

In comparison to many other LSCBs, Hounslow remains relatively underfunded in cash terms, though there are some LSCBs with a smaller budget. Those with a smaller budget usually have a smaller population or a reduced complexity of safeguarding issues, both of which we know are increasing in Hounslow. The Chair of the Board successfully negotiated an increase in the contribution from the Hounslow CCG by 10k from 2018-19 improving the Boards financial position slightly for the coming year. The Chair of the Board continues to request that the partnership acknowledges the funding pressure and identifies how they could increase funding for the Board to meet its requirements and drive the agenda of improvements forward. See Appendix A for expenditure breakdown.

8) Challenge, Assurance, & Collaborative Working

The work to improve the Boards challenge and scrutiny function of partners has continued to develop over the last financial year; momentum and expectation set by the Chair has been further embedded.

HSCB Development Day 2017

The HSCB held its first Development Day for all board and sub-group members on 16th May 2017. The aim of the session was to review successes, improvements, and how the board would implement the changes required by the Child and Social Work Act 2017.

The themes and priorities identified at the Development Day were collated with the outcome of the HSCB Challenge Day in February 2017 and formed the structure of its three-year business plan. The business plan was agreed by the Board in September 2018 and implemented 1st April 2018.

Challenge Day

In March 2018 the HSCB held its second Challenge Day, where it reviewed the progress made against the areas of challenge and improvement identified by partners following the Section 11 audit in January 2017 and requested each partner to identify 3 new areas of challenge and good practice.

Significant strides had been made by all agencies in the last year to progress the areas of challenge identified in 2017 which was positive given the ongoing pressure all services are under. It was evident that there are strong safeguarding practices in place and the multi-agency system is improving, and the commitment to the work partners are doing to ensure children in Hounslow are safe is ongoing.

Some areas of challenge identified in the previous year remain static and some newer emerging thematic areas of challenge were identified by all agencies individually prior to this year's challenge session and triangulated through collective discussion.

The areas identified were taken forward and considered as part of the HSCB Development Day 2018 and discussed how the Board or its partner agencies were addressing the issues and if appropriate they could be included in the next business plan.

Thematic Areas of Challenge:

Areas of challenge identified and already featured in the 2018-21 Business Plan and no further discussion required:

- Definition of mental health for young people
- Thresholds of referrals
- Early Help Strategy and offer
- Engagement with education providers

Areas of challenge to be discussed at the HSCB Development Day 2018 to determine strategic responsibility:

- Consistency of practice and procedures
- Think Family
- Resourcing support for vulnerable adolescents

In the year ahead the HSCB along with its strategic other Boards are considering how to baseline the Think Family agenda across the adults and children's safeguarding economy considering resource impact and practice definitions.

Adults Mental Health Engaging with Child Protection

The Joint Targeted Area Inspection (JTAI) found that there was not consistent representation from Adults Mental Health Social Work at Child Protection Conferences, especially in cases where there are the factors of substance misuse, domestic violence and mental health in the parents. The Board requested a paper to understand how the communication between services is working and receive assurances that process were being developed to resolve the issue.

It was identified that there is need to establish an understanding of Children's Social Care and Adult's Mental Health services core areas of work and where the links can be bridged between them. There are key professionals in place committed to improving these working arrangements. Adult's Social Workers are undertaking children's safeguarding training and seminars across adults and children's services are jointly taking place on issues of Domestic Violence, Mental Health and Substance Misuse.

A system is in place to secure wider involvement of mental health services in Child Protection Conferences and further work with the Local Authority's Adult Social Care Mental Health Team will reflect the process. The effectiveness of this system will be reviewed and further improvements made where required.

The mutual understanding of both the adults and children's safeguarding context strongly links with the Think Family approach. As outlined earlier in the report, both the Children's and Adults' Safeguarding Boards will continue to work together throughout 2018-19 and beyond to develop, adopt and embed some of the key principles of Think Family.

9) Joint Targeted Area Inspection (JTAI) of Children Living with Domestic Abuse

In March 2017, Hounslow received a Joint Targeted Area Inspection (JTAI) with the deep dive theme of '*children living with domestic abuse'.* Hounslow was the final local authority out of six to be inspected under this theme.

The purpose of the inspection was to evaluate Hounslow's 'front door' and safeguarding services across agencies that work with children, young people, and their families. As well as assessing front door services, the inspection also considered the response to specific children and young people through a 'deep dive' theme.

The Ofsted report found that:

"Hounslow Council leads a strong culture of openness and learning."

"There is evidence of purposeful, child-centred direct work with children and their families, who are safer as a result"

'Prioritisation of domestic abuse has led to some good and excellent services being available to families where children have experienced domestic abuse. The *Learning to Respect* and *Let's Talk* programmes and the *White Ribbon* campaign were particularly highlighted"

Partners View of the JTAI

Professionals in Hounslow are proud of our working partnership and continuously seek to improve its effectiveness. The JTAI enabled a shared understanding of our joint service offer and practice highlighting the good and excellent services the partnership is providing. The inspection offered insight and areas to improve where we can work better together.

The range of strengths identified during the inspection have been shared with other local areas. The priority Hounslow has given to tackling domestic abuse, which has led to some good and excellent services being available to families and purposeful, child-centred direct work with children.

Hounslow's Response to Inspectors

The outcome of the JTAI has been widely shared across partner organisations. A partnership action plan was developed to address the areas of improvement and submitted to Ofsted in September 2017.

The four areas for improvement were developed:

- Multi-agency Safeguarding Hub (MASH).
- Performance information, monitoring and evaluation.
- Standards of Practice.
- Response to Domestic Violence and Abuse.

Monitoring and challenge of the multi-agency action plan has been the responsibility of HSCB. Partners have been involved at both an operational and strategic level through a series of multi-agency workshops, single agency leadership teams, as well as specific monitoring meetings to discuss individual areas for development.

Response from Ofsted

Ofsted's response to our action plan was:

''The action plan reflects an understanding of the key issues identified and does address all of the points raised in the JTAI letter with the exception of the actions that relate to London Community Rehabilitation Company"

The HSCB had actively and persistently attempted to engage the London Community Rehabilitation Company (CRC). Between March 2017 and December 2018, there continued to be a lack of engagement. During this time, CRC released a London wide statement informing that they were taking an ''offline approach'' until December 2017 when Partnership Managers would be in place. In April 2018 the Chair of the Board met with Senior Personnel from CRC following a request from its Chief Executive to discuss the concerns Hounslow had presented to Ofsted in their response to the JTAI.

Improvements Delivered by the Partnership in 2017-18 include

A larger fully-staffed, dedicated MASH team was created with a new lead Team Manager, additional specialist Nurse, part time Housing representation and some uplift in virtual membership and virtual representation from the National Probation Service**.**

The MASH data report was refined and analysis improved, which is reviewed by the MASH Operational Group, MASH Strategic Board and the HSCB. This has strengthened multi-agency evaluation, monitoring and challenge. The HSCB is supporting the improvement of the quality of referrals and understanding of 'front door' processes and is prioritising training for schools because they make the largest proportion of contacts and referrals. The Community Rehabilitation

Company (CRC) is introduced new, local performance and partnership roles which will oversee the interface with children's social care and drive improvement in the quality of referrals.

In order to better understand Recruitment of a partnership analyst to coordinate community safety data, including domestic abuse data, across the HSCB, Community Safety Partnership (CSP) and Hounslow Safeguarding Adults (HSAB) Boards.

Across the partnership there has been an introduction of a new GP information sharing form and new reporting format commissioned by the Violence Against Women and Girls Strategy Group (VAWG) to MARAC to maximise information sharing and contribute to solid risk assessments and decision making. Housing and Children's Services drafted a Joint Protocol to improve information-sharing and decision-making for families and young people at risk of homelessness.

The Let's Talk programme was extended through an older children's group which is being piloted from September 2017 and work underway to clarify how agencies assess and intervene with perpetrators to inform our next steps and service development.

Evaluating impact

To evaluate the impact of the joint action plan considerable work has been focused on the performance reporting to support better monitoring, challenge and evaluation and to inform review of practice. This includes a survey of partners and feedback from service users views on the police response to domestic abuse.

An external re-audit of the MASH was commissioned by the HSCB in December 2017 to measure improvement from the initial external audit in October 2016 and the JTAI in March 2017.

Continued Challenges for the Partnership to address in 2018-19

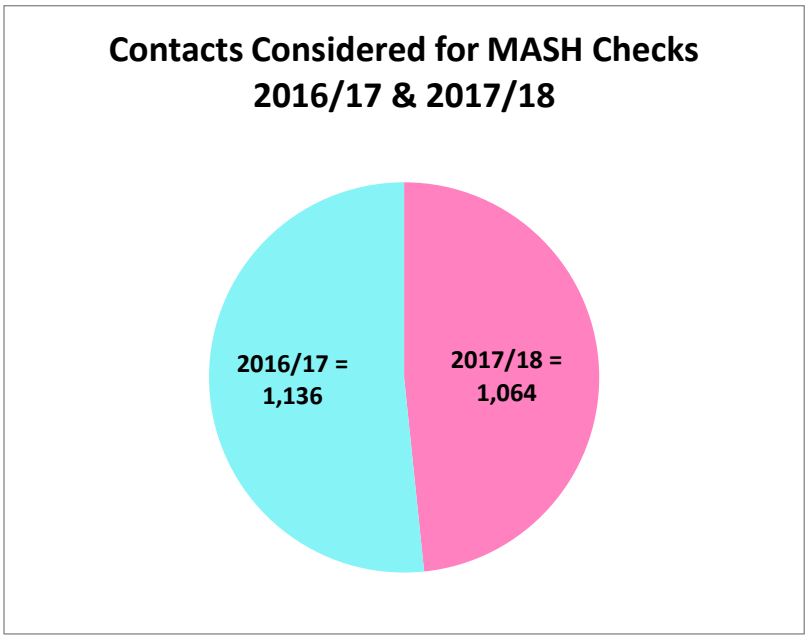
- Quality of Child & Family Assessment Notifications (CFAN)
- Timeliness of MASH checks from Health partners
- Strategy discussions involving Health partners
- Implementation of the new Police Safeguarding Structure
- Impact Probation Service check

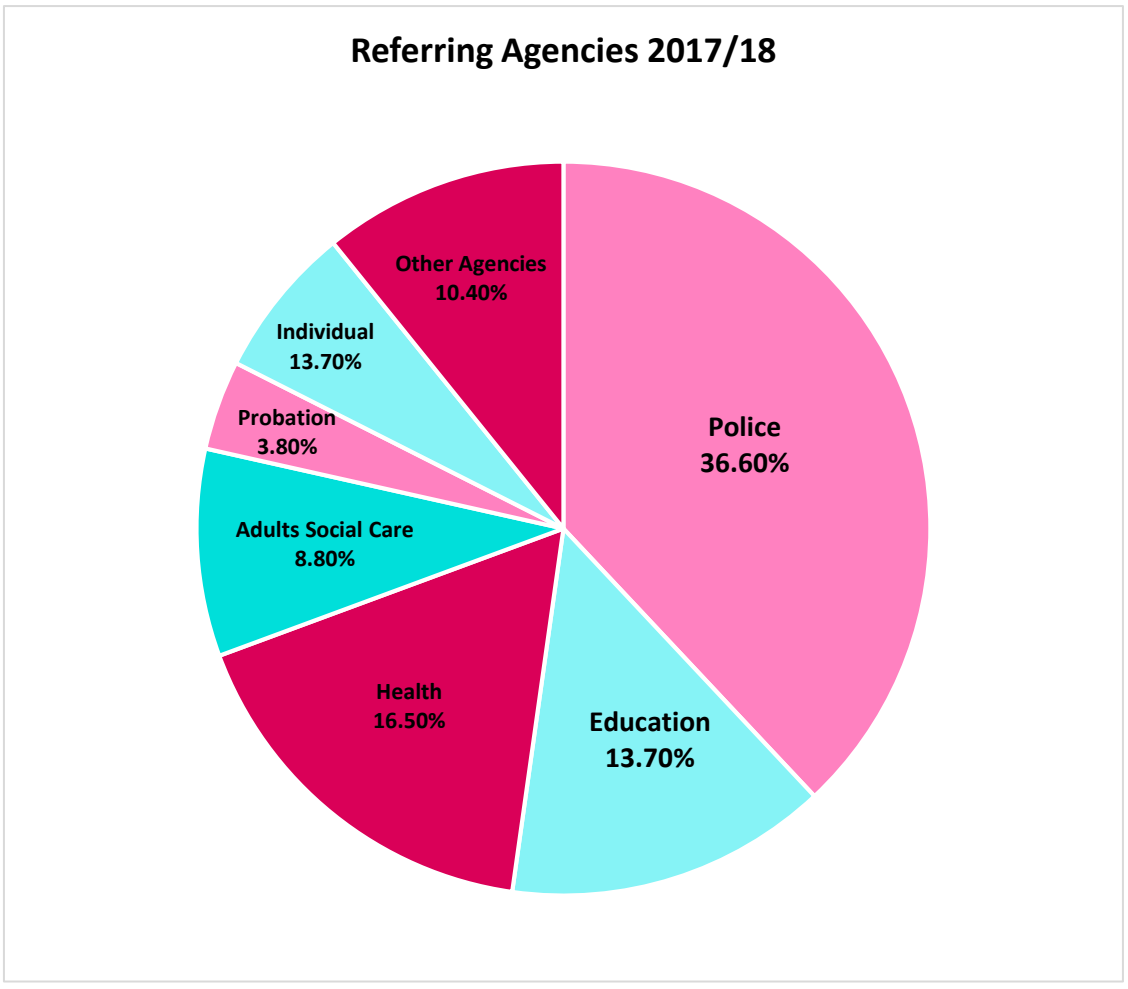
Practice and service challenges remain as we move into 2018-19.

10) Safeguarding in Hounslow – A Child's Journey

Multi Agency Safeguarding Hub

The Board has begun to collect data from the MASH as part of its data set, which is reviewed by the Quality Assurance and Performance sub-group and shared with the Board for further scrutiny. The end of year data shows that:





A total of 1,064 contacts were considered for MASH checks, which was 4.0% of all contacts received at the Front Door and broadly in line with 2016-17 with the most common reason for contact being made was Domestic Violence.

The top three referring agencies continue to be Police, Health and Education providers completing 67% of referrals to MASH in 2017-18, which is consistent with previous years. Of the 1,064 contacts considered for MASH checks, consent was sought for 895 (84.1%) contacts. This was 10.8 percentage points higher, and thus an improvement, compared to 2016-17.

Overall during 2017-18, 73.6% of the MASH checks were completed within 24 hours and 81.7% of the checks were completed within 48 hours.

Monitoring of the MASH

The Board has continued to focus on the monitoring and challenge of the MASH and its partner agencies throughout 2017-18 and sits within the existing governance structure of the MASH Operational Group and MASH Strategic Board. Progress reports have been received at each board meeting throughout 2017-18. Many of the actions identified as an outcome of the independent audit undertaken in October 2016 were echoed in the JATI, therefore monitoring of the MASH actions has been combined with the monitoring of the JATI.

Two areas of improvement remain static and continue to test the partnership function of the MASH: timeliness of MASH checks from health partners and as managing the level of contacts at the Front Door. This reflects the need for coordinated Early Help offer.

Early Help and the development of purposeful offer is an additional area of challenge that has received attention from the Board throughout 2017-18 and will be outlined later in the report. It has been acknowledged that cases being stepped down into existing ''early help'' services is still an area for development. Health partners have been working to address the issues identified; however, a solution has not yet been achieved and this work continues into 2018-19.

External Scrutiny of the MASH

A repeat audit of the MASH was undertaken in 2017 to test the improvements made since the audit in 2016 but more importantly since the JTAI. Many of the actions and recommendations from the JTAI had already been implemented.

The MASH audit report was reviewed and accepted by the MASH Strategic Board and the recommendations were accepted and incorporated into the rolling improvement plan.

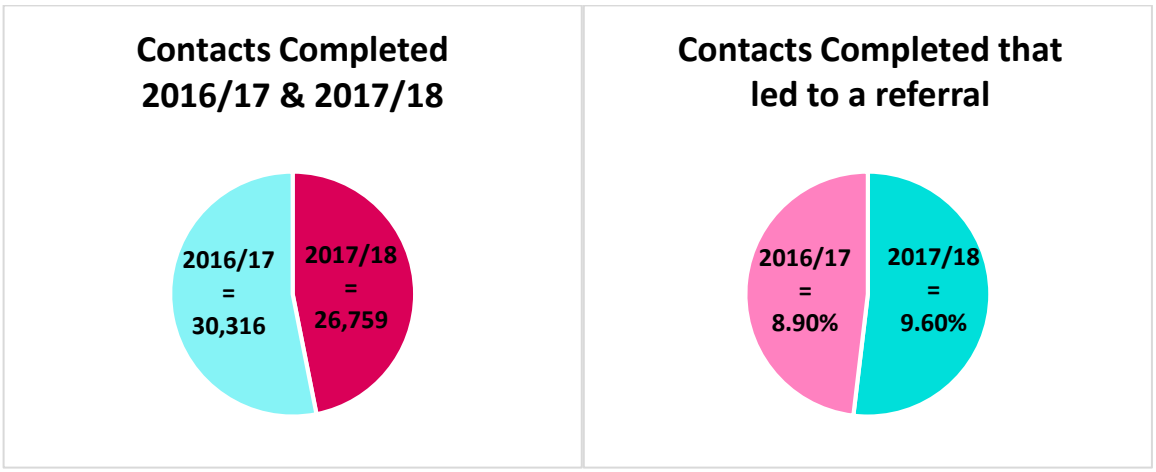
The audit found that there have been developments in the team since the previous audit in 2016, which is beginning to improve the way the MASH functions. The MASH team has a dedicated manager who takes a strategic lead in development work within the MASH and a Screening Social Worker now sits alongside Business Support Officers to offer advice and contribute to initial RAG rating. The audit identified a limited number of partner agencies are co-located, contributing to cases being dealt with out of timescales, as there is too much reliance on electronic returns.

An Access to Interventions Panel serves as a referral pathway into more targeted services. Repeat contacts are high and the number of repeat contacts should be kept under review, although better use of the Panel in cases stepped down which may positively impact repeat contacts. Bespoke screening tools are being developed for dealing with cases of Domestic Abuse and Neglect which will assist with risk assessment and identification of need.

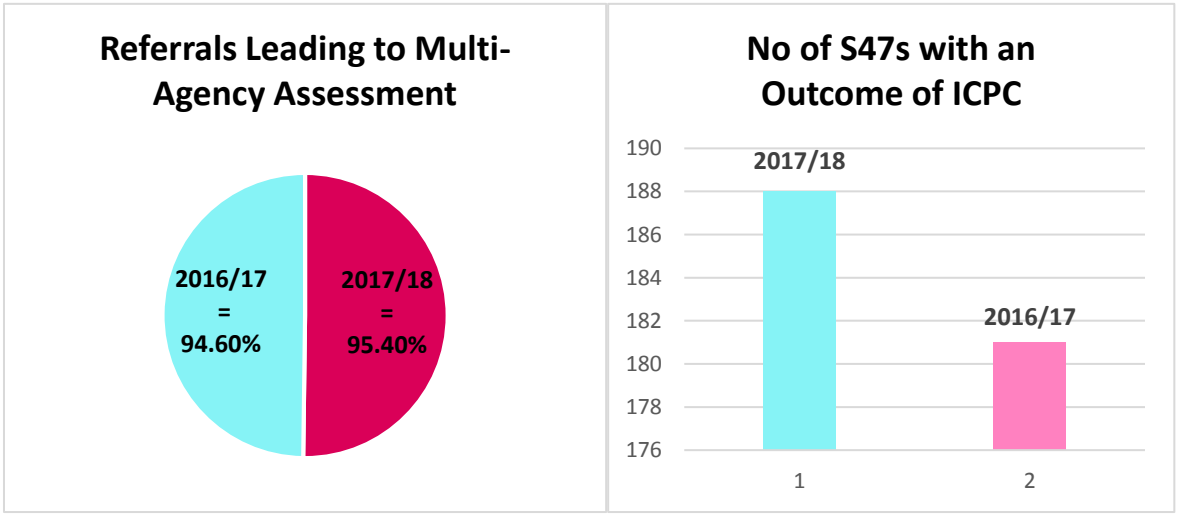
MASH practitioners have developed a tailored training course on completion of the CFAN referral form through HSCB. Performance of partners' MASH returns is now monitored monthly and reported to both the MASH Strategic Group and HSCB.

The HSCB has retained the monitoring of the MASH as a themed priority area for 2018-21. It will continue to work collaboratively with its partners and support driving up improvements.

The Front Door



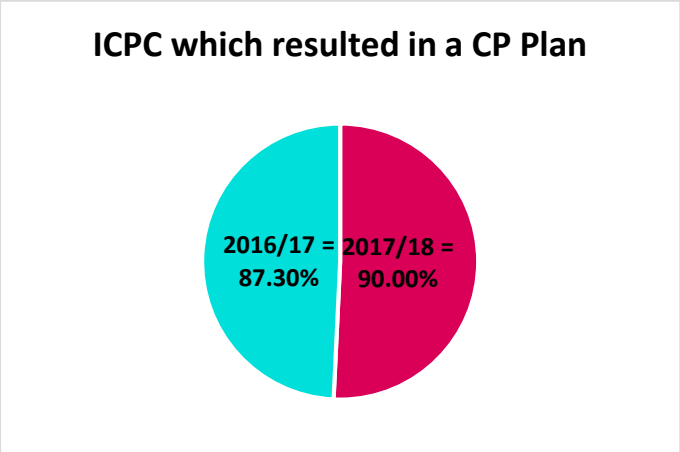
The number of contacts at the Front Door was 26.759, down 11.2% from the 2016-17 total of 30,316. This reduction is mainly due to a change in methodology applied from October 2017 to stop recording new contacts for cases with a currently open referral. This change is expected to cause a long-term reduction of 1/3 in reported contacts.



The final percentage of referrals leading to a multi assessment in 2017-18 was 95.4% and shows an improvement in performance of 0.8 percentage points on the outturn for 2016-17 which was 94.6%.

The final percentage of assessments completed within 45 working days during 2017-18 was 79.2%. This shows an improvement in performance of 1.3 percentage points on the 2016-17 outturn of 77.9%

The final percentage of Initial Child Protection Conferences (ICPC) held within 15 working days during 2017-18 was 86.2% and shows an improvement in performance of 8.5 percentage points on the 2016/17 outturn of 77.7%.

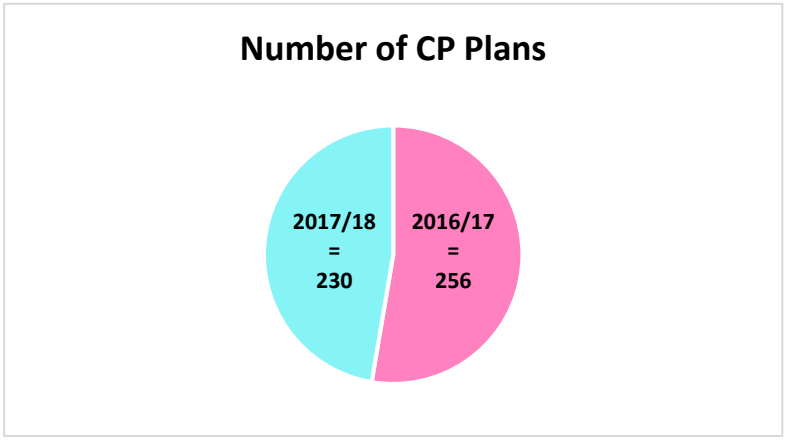


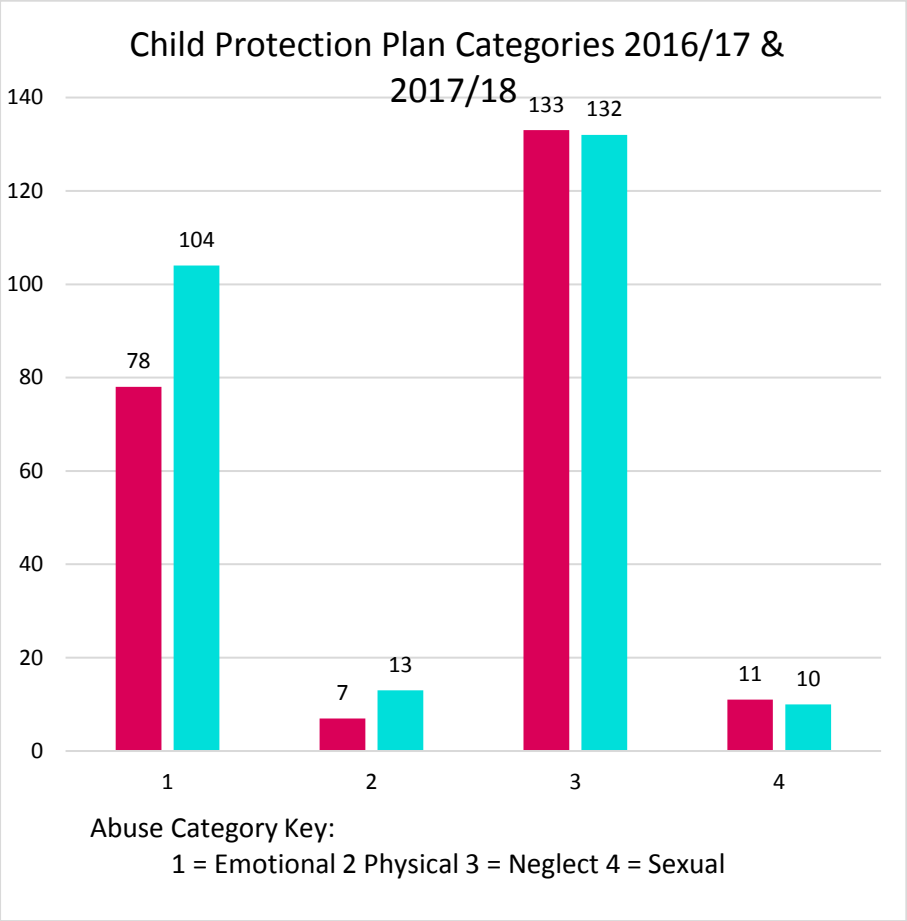
ICPCs resulting in a CPP has increased in the last year with 90% of conference decisions being to implement a protection plan. This shows that appropriate decisions and assessments of risk are being made early and the decision to escalate to Child Protection is evidenced.

Overall, the data demonstrates that the MASH and Front Door Service is performing consistently with previous years. In order to continue to improve understanding of thresholds in Hounslow and ensure that the system is not being blocked by inappropriate referrals, training and awareness of the thresholds and referrals into Children's Social Care has been and will continue to be undertaken through the HSCB training offer.

As highlighted in last years annual report, the disaggregation of the Early Intervention Service and the relocation and removal of some of the services has continued to have some impact on referral rates into Hounslow's Front Door. Throughout 2018-19 as outlined in this report considerable work efforts will be made by all partners to support the development on an Early Help Strategy which can support the early intervention into families lives and in the longer term contribute to the reduction in families requiring specialist interventions.

Child Protection Plans





Comparator Data for Child Protection per 10,000

Child Protection Plans	2017/18	2016/17		
	Hounslow	Hounslow	England	Outer London
Number of:				
Children who became to subject of a CP plan	**262**	298	66,180	6000
Ceased to be on a CP Plan	**290**	253	65,200	5890
Rate per 10,000 for:				
Children who became to subject of a CP plan	**41.2**	46.9	56.2	47.9
Ceased to be on a CP Plan	**45.6**	39.8	55.3	47.0

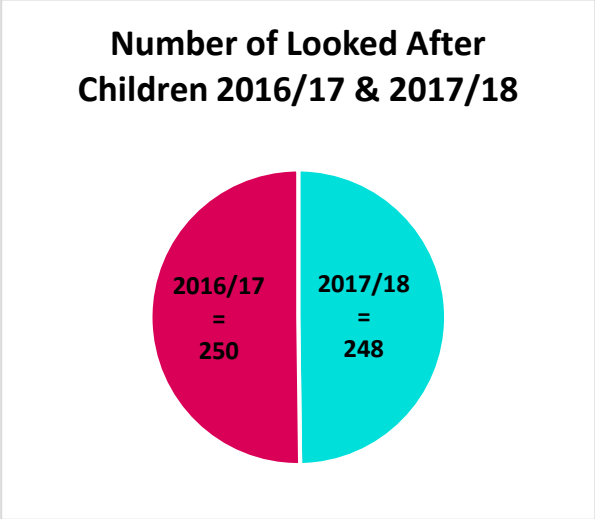
The number of children subject to a Child Protection Plan (CPP) over in 2017-18 has seen a minor decrease however the largest proportion of reasons for becoming subject to a plan is for neglect, followed by children and young people on child protection plans who were identified as being emotionally abused.

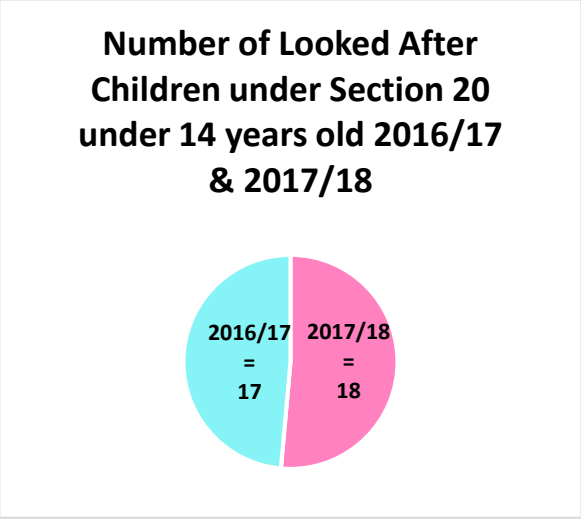
The final percentage of children becoming the subject of a CPP for a second or subsequent time during 2017-18 was 15.6% (41 children) and shows a deterioration in performance of 2.2 percentage points compared with the outturn for 2016-17 when it was 13.4% (40 children).

The final percentage of CPP ending after 2 years or more during 2017-18 was 5.2% (15 children) and shows a deterioration in performance of 2.8 percentage points on the 2016-17 outturn of 2.4% (6).

The final percentage of children with a current CPP lasting 2 years or more during 2017-18 was 6.6% (15 children) and shows a deterioration in performance of 3.5 percentage points on the 2016/17 outturn of 3.1% (8 children).

Looked After Children





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**
2016/17	250	40	62	45
2017/18	**248**	**39**	n/a	n/a

There were 248 Looked After Children (LAC) as at 31st March 2018 which was two fewer children than the previous year. This is consistent with the downward trend in LAC as at numbers over the past 5 years.

Of the 248 LAC as at 31st March 2018, 66 (26.6%) were placed in residential care, which was 10.6 percentage points (26 more children) higher than the outturn for 2016-17 which was 40 (16.0%) children. This increase was due to several older children with highly complex needs requiring a move to a residential setting from an In House or IFA foster placement.

Of the 248 LAC as at 31st March 2018, 18 children (7.3%) were accommodated under Section 20 who were under the age of 14, which was in line with the outturn for 2016-17.

Missing from Home, Care & Education

The number of children reported missing from home dropped to 181 children during 2017-18, compared to 190 the previous year.

The number of children reported missing from care dropped to 38 children during 2017-18, compared to 57 children the previous year. This was the lowest reported number of missing children from care in the past 5 years.

The number of missing episodes from care also fell to 293 in 2017-18, from 313 in 2016-17, maintaining a long term downward trend.

Last year the Board received the first Missing Education Annual Report for Hounslow. The report was considered at both the Board meeting and the Missing and Vulnerable Sub-Group.

In September 2016 legislation was revised and now places additional pressure on the Local Authority due to the increase in referrals and cases are not closed until child's whereabouts have been identified. Compliance with the new legislation is required by OFSTED and all schools including independent provisions must ensure they are in fulfilling their duty.

The most common factors for a child to be missing education are for those who have moved into Hounslow and are placed by other local authorities in temporary housing. Parents are often reluctant to enrol their children in school, as many are unsure of how long they will be placed in the borough.

There has been an increase in the number of children arriving to the UK with Special Educational Needs (SEN) who are lacking documentation. This is being addressed in Hounslow by developing a new form to ascertain more information from the parent which may help SEN or Admissions to place the child.

Children moving abroad is also a challenge. In the last year, Hounslow has developed a relationship with the Border Agency who are assisting in locating those children although criteria for searches is strict and the rationale needs to be evidenced by the Local Authority before they release confidential information.

The Missing Education Annual Report has been placed on the Boards forward agenda plan to ensure that it continues to be sighted on the emerging issues and challenges and ensure there is a collective multi-agency responsibility for services to work closely together.

11) HSCB Targeted Priorities 2016-18

In March 2016 the Board determined its new priorities for 2016 -18 in the light of the issues for Hounslow and emerging national themes. Below the report outlines what progress has been made under each area of priority throughout the last year, what more needs to be achieved and how practitioner's views and the voice of the community and young people has been sought.

Priority 1 - Safeguarding Children from Sexual Abuse

- **NSPCC PANTS Campaign**

Professionals who attended the HSCB Child Sexual Abuse Annual Conference in 2016 collectively agreed that one of the most effective things they could do locally to stop more children from coming to sexual harm was to encourage parents and children to talk together about how to stay safe and NSPCC's PANTS provided the framework to develop these conversations.

The aim was to deliver a campaign across Hounslow to protect children from sexual abuse by encouraging parents, carers and professionals to have conversations with children in an age-

appropriate way about how to stay safe from sexual abuse. The campaign was run in partnership between the HSCB, Hounslow Council and the NSPCC.

What was achieved

Over 500 professionals engaged in the campaign including early years settings through launch events, training sessions, presentations and forums, team meetings and voluntary groups. Approximately 1,155 parents and carers were engaged directly through information sessions in schools, church groups and community sessions and 6000-7000 children were reached through delivery of PANTS in classroom sessions in primary schools.

We know that communities now have enhanced skills and knowledge to act to safeguard children with parents and professionals who attended the workshops feeling more confident about having conversations with children about keeping safe from abuse.

The scope of the campaign included engaging more specialist services for children with disabilities and attempted to do so, but the response was not forthcoming. We are hopeful about reaching those services in the coming year.

The HSCB will continue to support the PANTS rule as part of their wider safeguarding activities and has incorporated it in the safeguarding training for professionals and in wider information dissemination across the community. The Board will continue to promote PANTS and reach approx. 200 professionals annually and materials are now widely known in the borough. A 'PANTS WEEK' of activity to renew awareness for the campaign will be held in 2018.

While it cannot be directly related to the campaign activity, it is of note that figures from the NSPCC helpline show an increase in referrals to agencies in Hounslow overall, in relation to sexual abuse, over the duration of the campaign.

NSPCC Helpline Referrals	2015/16	2017/18
All referrals to agencies based in Hounslow	114	139
Referrals about sexual abuse to agencies based in Hounslow	11	25

- **Child Sexual Exploitation (CSE)**

The priority of CSE was continued from the previous year as the HSCB wanted to ensure that collectively it remained proactive in responding to the growing national concerns regarding CSE.

The Board wanted to ensure that it did not become complacent about the safety of young people who are exposed to CSE and the associated contextual risks. The Board recognises that for each affected child and their family, the impact is no less distressing than it is when the prevalence has been greater e.g. Rotherham, Oxford and the Midlands.

CSE Operating Protocol 2017

The CSE Operating Protocol 2017 became live in July. The protocol is non-statutory and was predominately produced to help practitioners and decision makers who work with children and families to identify CSE, take appropriate action in response and includes the management, disruption and prosecution of perpetrators. The protocol clearly sets out the aims and principles for safeguarding and protecting the welfare of children from CSE and how, through partnerships, CSE is assessed, challenged and target offenders to prevent and disrupt criminal activity.

The Hounslow Multi Agency Sexual Exploitation (MASE) Panel adopted the new protocol and amended its procedures to incorporate the new requirements and is now operating within its recommendations.

Multi-Agency Sexual Exploitation Panel (MASE)

Last year, as well as adopting the new operating protocol, the panel has moved to a more strategic function and progress has been made in the use of intelligence resulting in increased confidence in understanding the prevalence of CSE in Hounslow. The strategic aspect of the meeting focuses on the building intelligence and disrupting activity and is steering our preventative work. As with our neighbouring boroughs, some of the key themes that have been raised during the strategic meetings has been around hotels, parks, and late-night food retailers.

Hounslow's MASE has continued to focus on ensuring there are robust plans in place to protect children and young people who are at the highest risk of sexual exploitation. Reporting lines from MASE to the Missing and Vulnerable sub-group were developed at the beginning of 2018 and quarterly assurance reports will be received throughout the coming year.

At the end of March 2018 there were 19 young people who were overseen by MASE.

What was achieved

CSE leaflets for parents, carers, children and young people were created and translated into the three most commonly spoken languages in Hounslow. The leaflets have been promoted and are widely available on various local websites including the HSCB's and some schools. A Safety Plan tool was designed in consultation with the Children in Care Council to be used directly with young people to ensure they are included in the planning of their own safety.

The Missing and Vulnerable sub-group continued to oversee key aspects of the CSE strategy and targeted CSE actions. The strategy will be revised in the coming year to reflect the CSE Operating Protocol, incorporate learning from national reviews, and respond to the local profiling and emerging characteristics of perpetrators. A new multi-agency work plan will be developed which continues the success of the Partnership Improvement Plan and supports our response to the emerging complexities of CSE and ensures continued awareness raising.

The number of CSE Champions was expanded, including within the voluntary sector, which has supported us to reach a much wider population of community groups. The function of the CSE Champion programme will be developed further over the coming year to ensure ongoing collaborative working and sharing of information across partners and drive up CSE prevention activity across agencies.

A multi-agency E-Safety Statement was developed in conjunction with universal and early intervention services, which sets out the aims and objectives of the HSCB's approach to e-safety. This statement identifies key principles of an e-safety approach to improve the collective response to keeping children and young people safe online. It aims to educate, empower, prevent and protect young people and give them the right information and support to make better decisions and keep themselves safe while using technology.

Two Police operations were undertaken in the last year, Operation Amethyst focusing on hotels and Operation Buxton focusing on drug dealing in the Borough. Operation Amethyst found that some hotels failed to pick up on the potential CSE risk and a 12-month educational programme is being rolled out. Of the 29 people arrested through Operation Buxton, 23 were linked to CSE perpetrators, which demonstrates the emerging contextual elements of CSE. Further work will be undertaken in partnership with the Police to explore the link between CSE and contextual issues such as gangs, drugs and county lines.

A Provider Forum was held to raise awareness of areas such as semi-independent units, foster carers, missing from care, CSE, group crimes, exploitation, extremism, prevent agenda, transitioning into adulthood. The forum was a success and will be repeated in 2018-19.

Both the Missing and Vulnerable sub-group and the Cases sub-group have considered Serious Case Reviews from other areas to expand the Boards thinking about what the national issues emerging are in relation to CSE and explore how we can incorporate those lessons into our response locally.

The SCR of ''Jack'', a 13 year old boy subject to on-line grooming, which escalated to serious sexual exploitation was considered by the Missing and Vulnerable sub-group in 2017 The review identified that there is significant under reporting of the exploitation of young gay males and appropriate services are not available to support both straight and young gay males. As a result, the sub-group scoped what services were available for boys and promoted them on the HSCB website and has updated the CSE training was to incorporate the learning from the review.

Training Activity

The Board has continued to run three CSE related courses as part of its face to face training offer and has updated the course content throughout the year to include a focus on trafficking, new materials and resources and included lessons identified through case review discussions.

1) Bwise2 Child Sexual Exploitation
2) Safeguarding Young People at Risk of Gang Involvement
3) Safeguarding children from Child Sexual Exploitation and Inappropriate Internet Exposure.

The HSCB now regards CSE as ''core business'' as reflected in its 2018-21 business plan. Despite the board not focusing on CSE as a targeted priority in the coming year, HSCB will ensure that considerable focus remains on the exploitation of children and young people ensure that the partnership continue to strengthen its strategic approach.

- **Child Sexual Abuse (CSA)**

CSA Prevention Plan

The HSCB annual conference in 2016 about familial sexual abuse led to the development of a prevention plan for Board. Considerable progress has been made in all areas of prevention plan throughout the last year, building on the achievements from 2016-17, predominantly focussing on training and raising awareness activity.

What was achieved

A programme of engagement with parents of secondary schools was implemented. The programme reached 445 parents at 5 secondary schools with the aim is to raise awareness of sexual abuse risks and offer them access to resources and materials to further educate themselves and most importantly to talk to their children.

A key element of the plan was to review professional learning needs to ensure they have the skills and confidence to appropriately tackle the uncomfortable issue of CSA. A multi-agency survey was completed which identified key areas of weakness across the professional network. In response to the outcome of the survey training programme will be developed to support professional learning needs and build staff confidence and expertise. Distinct barriers in having conversations with children about sexual abuse were highlighted. Professionals acknowledge that they do not have the confidence in talking to children about sexual abuse.

Findings from the seminar will be incorporated into the learning needs review in the coming year.

Training Activity

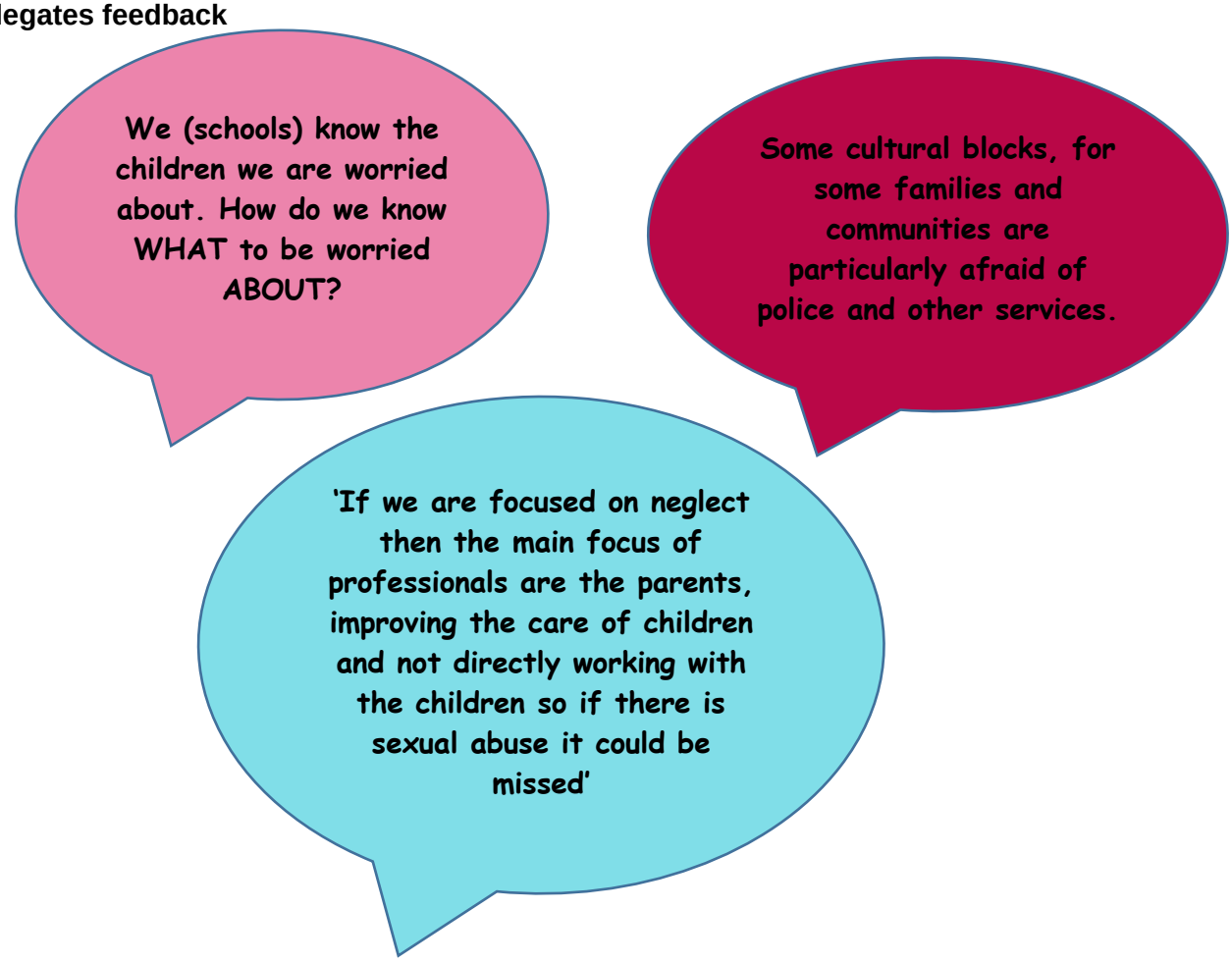
Familial Sexual Abuse Seminar

The seminar was designed to explore the powerful barriers to children 'telling' and the low confidence of many professionals in working with this area of safeguarding concerns.

The seminar posed two key questions:

1. What gets in the way of professionals recognising sexual abuse of children?
2. What are the blocks?

Delegates feedback



Priority 2 - Harmful Practices

- **Female Genital Mutilation (FGM)**

Since 2014, FORWARD in partnership with Community Safety Partnership, Public Health and HSCB have been providing preventive service in the borough. The project has worked with FGM affected communities to empower them through:

- Changing attitudes and behaviours to eliminate this harmful practice
- Improving the health and wellbeing of communities
- Safeguarding the rights of girls and women at risk of FGM and to support those affected.

What was achieved

- FGM resource pack developed in partnership with Board and shared across services and published on the boards website.
- FGM clinic was set up in Chelwest Hospital to provide advice, support and education for victims.
- Training provided to professionals which includes responsibilities under mandatory reporting
- 1166 teachers and school staff across primary and secondary schools trained to understand FGM risk factors and keep young girls safe from
- Support, advice and advocacy provided to women affected by FGM
- 18 Community Champions (men and women) trained to raise awareness and challenge attitudes in their communities
- Community awareness though events, stall, workshops and outreach session

Whilst the project has been remarkably successful and achieved solid and sustainable outcomes, further work remains in two key areas of training and data collection. There is a high demand for training from professionals which is difficult to meet as the project has significantly reduced capacity due to funding pressure and has focused on establishing the support and advocacy service. NHS data showing FGM cases in Hounslow and across London remain low and there is an identified weakness in this area. Data reporting arrangements will be scrutinised over the coming year as part of the workstream by the Health Network to ensure all identified FGM cases are reported.

Training Activity

To support the work of FORWARD in Hounslow the Board has continued to offer both face to face and online training. Courses that will continue to be available to all professionals in Hounslow are:

1) *Female Genital Mutilation, Exposure to Extreme Beliefs and Radicalisation, Modern Slavery and Forced Marriage*
2) *An Introduction to FGM, Forced Marriage, Spirit Possession and Honour Based Violence.*

- **Modern Slavery & Child Trafficking**

The HSCB joined the Modern Slavery sub-group set up by the Community Safety Partnership Board to scope and organise training on modern slavery and ensure that

Hounslow is meeting its statutory duty to refer potential victims of modern slavery to the National Referral Mechanism (NRM). The group has met since 2016. It consists of representatives from:

- London Borough of Hounslow (LBH)
  - Community Safety
  - Adult Safeguarding
  - Children's Services
  - Housing Client Services
- Hestia
- West London Mental Health Trust
- Hounslow & Richmond Community Healthcare
- Hounslow Clinical Commissioning Group
- Chelsea and Westminster Hospital NHS Foundation Trust
- Human Trafficking Foundation

What was achieved

A Single Point of Contact (SPOC) has been identified in Children's Services to provide advice and guidance in relation to trafficking cases and improve information systems to ensure that there is a consistent approach to child trafficking in Hounslow.

The London Safeguarding Trafficked Children Toolkit (February 2011) continues to be the main reference point for Children's Services staff where trafficking may be an issue. The Toolkit provides a clear and comprehensive child trafficking risk matrix which supports staff in determining whether trafficking may have occurred and thus whether an NRM referral is required.

Training Activity

A range of online and face to face training options are offered through the Boards training programme and available to both the children's and adults workforce. Courses that are available are:

1. *Asylum and Trafficking*
2. *Identifying and safeguarding suspected victims of child trafficking*
3. *Trafficking exploitation and modern slavery*

Priority 3 - Protect Children from Neglect

Neglect is identified as one of the highest reasons for accessing services in Hounslow. Over the last 4 years neglect has consistently accounted for approximately 50% of the cases made subject to a Child Protection Plan.

In response to this, the Board recognised that only a proactive, co-ordinated, multi-agency approach would be effective in achieving better outcomes for children impacted by neglect.

Three work streams were identified to target this issue;

1. Update and re-launch the existing evidence based structured judgement Quality of Care Assessment (QoC) Tool
2. Develop a multi-agency neglect strategy

3. Audit the effectiveness of the multi-agency response to neglect

What was achieved

The Neglect Strategy was launched in 2017. A time limited task and finish group facilitated and monitored the implementation of the strategy. Through an effective communication plan, we know the reach of the agencies who are aware of the strategy and the drive to address neglect are:

- Children's Services
- Adult's Services
- Community Safety
- Schools
- Early Years
- Police
- All health providers including GP's, Dentists and Maternity services
- Libraries
- Public Health
- Community Services
- Housing
- Parks and Leisure

Neglect position reports from all child facing and key adult facing agencies were discussed at the Board in November 2017. The reports provided assurance of how services were embedding the strategy, the range of tools they use to assess neglect and how vigorously they responded to concerns of neglect.

A multi-agency thematic audit focussing on neglect was undertaken in November 2017. A small cohort of four Child Protection cases were audited. The audit focused on:

- Assessment and identification of risk and needs
- Decision making, planning and quality of intervention
- The child's experience
- Family engagement
- Multi-agency work

Audit findings provided a picture of the partnerships overall response to neglect and evidenced both strengths and areas of improvement. Areas of strong practice were highlighted in child focused assessments being completed by all partners individually and strong multi-agency working throughout the life of the Child Protection Plan. The audit identified that in particular, the partnership needs to improve its collaborative multi-agency assessment of risk, with regular and consistent use of the QoC Assessment Tool. The audit made six recommendations, which are being taken forward by the Training and Missing and Vulnerable sub-groups.

Additionally, the audit process aimed to hear the voice of the child, parents and practitioners of the cases selected, as outlined in the HSCB's Quality Assurance Framework. Where possible, the families and young people who were selected were consulted on their views about how the partnership worked with them whilst subject to Child Protection Plans. All of the children and young people who could share their views, reported that they felt listened to by their professional network with one young person regularly attending their Child

Protection Case Conferences to give their wishes and views and reported to feel empowered by attending.

Practitioner learning sessions were held on two of the cases bringing together all practitioners and auditors involved to facilitate joint learning and to consider the audits that had been completed. During the sessions practitioners identified that neglect is complex and one of the most challenging areas to work in and achieve successful outcomes due to the range of underlying factors. The complexities and chaotic nature of neglectful families challenges the focus of Child Protection Plans as they are often ''firefighting'' and responding to crisis and not assessing historical risk factors. Completing the QoC Assessment tool as a multi-agency partnership would be the most effective way of using the tool and ensure full ownership from all professionals.

A repeat audit has been commissioned for November 2018 and will sample a larger cohort of children to include Child Protection, Child in Need and children being supported by Early Intervention Services. Widening the scope of the audit will allow the Board to build a picture of how well the partnership is responding not only within the Child Protection arena, but whether we are effectively intervening early in children's lives to prevent escalation. The audit will also consider the extensive awareness and learning activity that has taken place throughout the last year and make an assessment as to whether the strategy has been effective in improving practice.

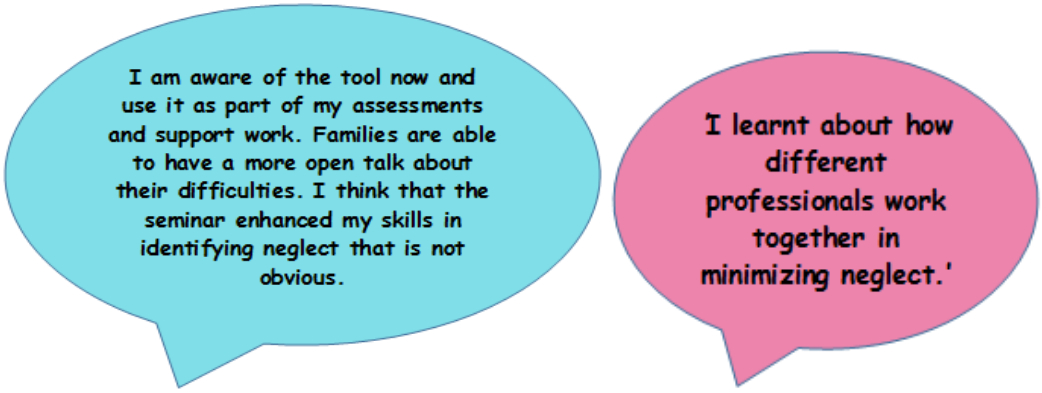
The QoC Assessment Tool has been widely adopted by the partnership and has been embedded into the Children's Social Care system. It is used in all cases where a child is subject to a Child Protection Plan for neglect. A streamlined version of the QoC Assessment Tool was developed for partner agencies to utilise when assessing neglect which would contribute to a consistent assessment framework being used by all partners and was a recommendation of the audit.

A review of multi-agency performance indictors will be prioritised in the coming year to build a meaningful dataset in line with the principles of the strategy and audit findings to support the Board in monitoring the impact of the strategy and response to neglect.

Training

Two 'Neglect Matters' seminars were arranged in January 2018 to launch the strategy and further promote the use of the QoC Assessment Tool. Both were well attended with approximately 120 professionals attending both sessions.

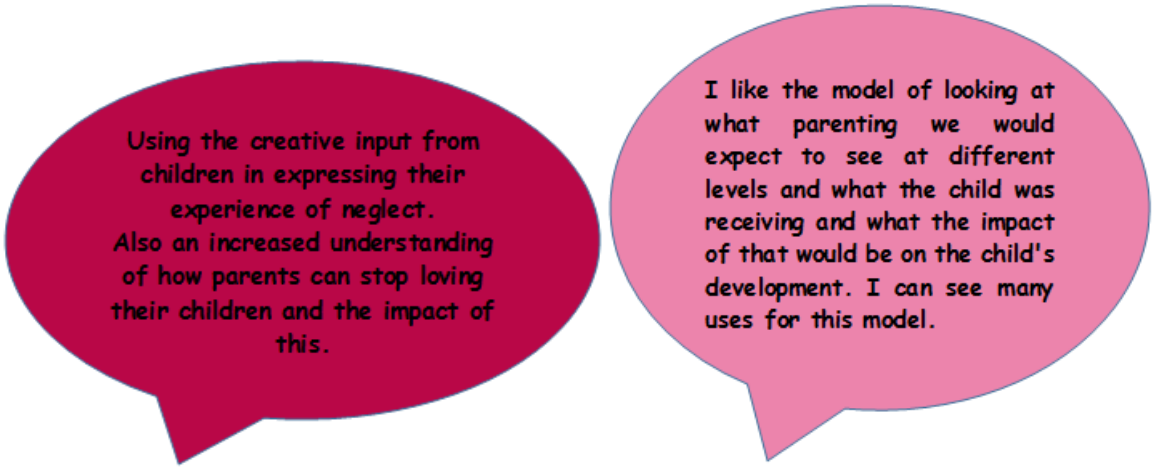
The seminars were facilitated by Jane Wiffin who delivers the HSCB's 'Neglectful Parenting' course and who also developed the QoC Assessment tool in partnership with Hounslow. Jane was supported by practitioners from health and the family support services who gave presentations about their experience of using the QoC. Some delegates feedback that they were not aware of the tool prior to the seminar, which reinforced the Board's rationale for re-launching it within a strategy.



The Board has continued to deliver its course on 'Neglectful Parenting' as part of its core training offer. The aim of the course is to:

- Enhance practitioner's appreciation of the complexity of neglect both in terms of underlying cause and the potential harm to children
- To promote the use of the QoC Assessment Tool based on the graded care profile
- Improve planning for children who experience deficits in the care that is provided to them by their parents

Delegate comments throughout the year suggest that for many people the aims are being achieved.



Priority 4 -Safeguarding Children with Specific Vulnerabilities

- **Children with Disabilities and Special Educational Needs (SEN)**

The 0-25 Disabilities Team and Special Educational Needs (SEN) Team is an integrated team based within the wider Children's Services directorate and provides social work support to people aged 0-25 with disabilities and specialist support to children with SEN. Both teams sit under the management of one Head of Service and two team managers.

The team is divided into two cohorts ranging from 0 -17 and 18-25 years of age. The overall service aim is to improve the transition points with an integrated approach, and a robust SEND Code of Practice to ensure continuity of service during transitions and to meet different expectations.

The Board received assurances that safeguarding practices of very vulnerable were understood and embedded in a service whose primary role is not safeguarding. The team works well to engage with partner agencies particularly in health to ensure a holistic service is provided to vulnerable young people. It was recognised that there remained challenges for the service such as developing stringer links with Children's Social Care and ensuring safeguarding practices is consistent.

To look more closely at safeguarding practices, the 0-25 Disabilities team was included in the neglect multi-agency audit. The rational for this was to explore if the approach to safeguarding is consistent whether a family is supported within the Children's Social Care service or within the 0-25 Disabilities Team. The audit evidenced that the services responded well to the wider safeguarding needs, as well as the disability needs of complex families. As a means of further

monitoring the safeguarding delivery of the service the board will actively include the team in all quality assurance work it undertakes and ensure the service is represented at key sub-groups.

The Board incorporated the topic into its Development Day in 2018 for further discussion as scheduled an updated report to be shared with the board later in the year.

- **CAMHS Systems of Support and Safeguarding**

As part of our priority to safeguard children with specific vulnerabilities, there was scope for the Board to consider the support offered to vulnerable young people who need to access the CAMHS service.

To understand the system for vulnerable children for whom mental health is an additional factor, the Board commissioned a paper from CAMHS in June 2017 which outlined the range of support mechanisms the service offers.

There is substantial support offered to children and young people through Tier 2 – 4 by multi-disciplinary teams of clinicians all of whom are level 3 trained in safeguarding.

West Middlesex University Hospital have access to a dedicated nurse provision for CAMHS admissions including out of hours support. Clinicians have a presence in identified schools to assess what the need of the school is for CAMHS input.

CAMHS is a service that significantly supports the safeguarding of children and young people by working closely with children's social care to support the continued clinical management of children who are subject to a Child Protection Plan, or require additional personal and familial support as a Child in Need. The decision-making process for prioritising when patients are seen is based on a clinical decision and not whether the young person is subject to a Child Protection Plan or a Looked After Child, although this may be considered in the decision making if appropriate. A further paper is scheduled for September 2018 relating to the waiting lists and prioritisation of children subject to Child Protection Plans.

Training Activity

The HSCB has continued to deliver the 'Introduction to Safeguarding Children with Disabilities' course. The course aims to, expand on hidden disabilities and specifically highlight the sexual exploitation of children and young people who have learning disabilities and further develop consideration of the ethical dilemmas associated with safeguarding disabled and very ill children.

The Mental Health First Aid (MHFA) is a nationally recognised course which equips the workforce with the knowledge and skill to promote better understanding of and initial response to mental health and mental ill health in young people and is supported by the Mayor of London.

In a drive to address the vulnerabilities of adolescent mental health and the gap in support to professionals and young people, Public health and HSCB worked in partnership to respectively fund and arrange MHFA instructor training.

Twelve Hounslow professionals from health, social care and education undertook instructor training in October 2017. It is anticipated that the accredited instructors will train up to 180 staff across all agencies in Hounslow throughout 2018-21 Feedback from staff who had attended the course confirmed that it had provided confidence to professionals who felt they had the capacity to deal with suicidal issues. Consideration is being given to extending the training to staff and officers in FYOI.

In addition, the Board has continued to offer 'Understanding and Working with Young People who self-harm' and 'Introduction to Suicide Awareness and Prevention' in part due to thematic learning identified by the Cases sub-group.

Whilst safeguarding children with specific vulnerabilities has been a themed priority area for the Board throughout 2016-18 and some work has been achieved it is has not received the same focus as other priority areas. Therefore, it was agreed that aspects of what is a very broad and complex issue would be refined and again be prioritised to feature as a targeted priority in the Board 2018-21 business plan.

12) Early Help

Early Help is an area of work that has continued to move up the agenda both in Hounslow and nationally over the last year. To continue the initial scoping started by the board in January 2017, a subsequent piece of work was commissioned in September 2017 to review the progress of developing a formalised Early Help Strategy. The HSCB was assured that the partnership was moving forward in developing their individual responses to Early Help and preparing to move into the next phase of integrating services into a combined offer.

The Children's Delivery Group formally took the strategic lead on the development of the Early Help Strategy with an agreed Governance reporting into the HSCB. The Early Help Partnership Board has continued to embed its function through a strategic and operational board. Two workshops were held in March 2018. One for Local Authority staff and the other engaged the wider multi-agency stakeholders. The workshops were used as a forum to bring together the intelligence that had been gathered throughout the year and synthesise it into the principles of the Early Help approach for Hounslow.

The Board will continue to seek assurances throughout the coming year and support the strategy as one of its targeted priorities over the next 3 years.

13) Feltham YOI (FYOI)

The Boards focus throughout the last year has been establishing good, transparent and cooperative relationships with staff at FYOI, as well as enhancing its independent mechanisms for monitoring. An extensive independent quality assurance programme was included undertaking two audits: one exploring the use of restricted regime, also known as Good Order or Discipline in June 2017 and the second scrutinising the Use of Force and Control and Restraint in October 2017.

The audits found that restricting a boy's regime to 23 hours in their room is applied consistently and lawfully in line with legislation and the reasons for remaining on restricted regimes were justified and proportionate. The use of Control and Restraint was used appropriately and the HMIP Inspection of FYOI in February 2018 supported the audit findings and noted that there had been a reduction in the number of incidents resolved using any form of restraint. Furthermore, the Safeguarding Advisor (covering the duties of Local Authority Designated Officer) developed a quality assurance processes such as "Lessons Learned" reviews with FYOI Safeguarding Team on cases where allegations of excessive force have been made against FYOI staff.

Further monitoring systems were put in place such as the collection and scrutiny of KPI's through the Boards dataset and the HSCB was regularly represented at internal meetings within the establishment to offer peripheral oversight and scrutiny of practice and ensuring that the Board had a visible presence in the day to day safeguarding operation. This will continue in the coming year.

The establishment was inspected in February 2017 and again in January 2018. Following both inspections, a detailed action plan was developed and regularly monitored at Board meetings and the FYOI sub-group. Overall the last inspection noted that significant improvement had been

made across the establishment in the 11 months since the last inspection. Regular assurance reports have been shared from the Head of Safeguards in relation to implementing recommendations from audit and inspection findings.

The Board has actively sought the views of young people while working with FYOI. A total of 35 young people were selected at random and spoken to directly whilst undertaking the audits to ensure that they could express their views directly. All young people reported that they felt safe with staff at FYOI.

Throughout the last 12 months the HSCB and FYOI have continued to work closely together. Evidence of this can been seen by the transparent way in which FYOI have engaged with the Board and how senior officers have valued the oversight and support the Board has given throughout a very busy year on their improvement journey. The collaborative work of the HSCB and FYOI was noted by inspectors during the HIMP Inspection in 2018.

The HSCB will continue to monitor and seek assurances from FYOI in areas of improvements identified in the recent inspection and support improvement work where possible.

14) Learning, Improvement and Workforce Development

Training Evaluation

The HSCB Training offer for 2017-18 included both face to face, e-learning courses and seminars. The face to face courses for the year reflected the board's priorities.

Attendees who participated in these face to face sessions, largely from Children's Social Care, Health, Schools Early Intervention and Early Years.

Evaluation of the online courses which were completed by users, found the course to be satisfactory or very satisfactory and meeting their needs.

The Board has sought to develop beyond the narrow delivery of training and changed its practice of convening an Annual Safeguarding Conference to adopting the HSAB's model of arranging safeguarding seminars throughout the year. To raise the profile of the Boards priority areas, the three seminars were offered on Familial Sexual Abuse, Neglect and Domestic Abuse. In the case of familial sexual abuse, the HSCB has gone much further to lead on the improvement of practice across all agencies as highlighted in section 11 of this report There are notable gaps in the uptake of training by the workforce in areas such as forced marriage and modern slavery that will be addressed in the coming year.

Outside of the thematic priorities, the Training sub-group has continued to support the overall learning and improvements aims of the HSCB through the provision of multi-agency and single agency training, seminars and the e-Learning offer.

In June 2017 the e-learning training offer was recommissioned jointly between the HSCB and HSAB. The offer was extended to include reciprocal access to both adults and children's safeguarding training topics to upskill practitioners and develop a broader knowledge of the issues that impact families in both the needs of the parent and the need of the child and thinking family.

In April 2018 it was agreed to merge the HSCB and HSAB Training sub-groups. The decision reflects increasing collaboration between the two safeguarding boards in recent years, with sharing of face to face courses and delivery of training seminars. This year seminars focused on children's needs were attended by an increased number of people from adult's services and were well received.

HSCB Training Strategy 2017 – 20

The multi-agency training strategy was revised and agreed in February. The strategy is supported by the HSCB Quality Assurance Framework is to provides a context for safeguarding learning and development so that staff and volunteers working with children, young people have access to training that assists in developing competence and confidence. The strategy also ensures the effectiveness of training and sets out the minimum standards for multi-agency training and single agency training.

The strategy aims to build an effective workforce whose practice is underpinned by best practice standards and develops frontline practitioners' expertise shaping the culture of learning in Hounslow.

The strategy will be revised again in the coming year to reflect the partnership between the HSCB and HSAB.

Learning from Case Reviews

The Cases sub-group has increased its learning activity and explored a range of both local case learning discussions, national case reviews and the Triennial Analysis of Serious Case Reviews.

Six cases were discussed, and one was considered to meet the threshold for formal case review.

Three national reviews were considered in the group and relevant themes and learning were extracted and shared with board partners to consider and incorporate into organisational functions wherever relevant. *See Appendix D*

Serious Case Review

During 2017- 18 the Board commissioned an SCR into the suicide of a young person. The review was not concluded by the end of the year under review. Intermediate lessons have been noted and are being acted upon by Partner Agencies. The Board anticipates that the Review will be completed in Autumn 2018 and the final action plan and how the lessons will be disseminated will be agreed, subject to an Inquest.

Outside of the learning activity the general focus of the group has continued to be supporting delivering the Boards business plan. There has been strengthened partner involvement and accountability to the HSCB with improved connections with the Training sub-group ensuring the flow of learning and implications for individual agency training is understood, shared and implemented. The Case Review sub-group along with the Training sub-group supports the development of a culture of reflection.

15) Quality Assurance & Performance

Throughout 2017 quality assurance and performance has continued to remain high on the Boards agenda and been a key focus for the Quality Assurance and Performance sub-group.

As discussed throughout the report the HSCB has significantly increased its audit activity undertaking multi-agency in MASH, thematic audit of Neglect and in focused audits in FYOI. Alongside this the sub-group has also increased its oversight of single agency quality assurance and performance activity which has included:

- Regular revision performance indicators on the HSCB's dataset assigning specialist areas of data for analysis to the relevant sub-group across all strategic Boards. Including scoping of Early Help data and consideration of building indicators into the dataset.

- Challenge of the disbandment of the core LSCB MPS dataset.

- Review of Children's Services Quality Assurance Annual report 2016-17, highlighting how findings from case audits, service user feedback, professional feedback is shaping service delivery.

- Review of two single agency audits undertaken by health services. One exploring attendance at A&E and notification to School Nursing following one of the findings in the Anita B SCR and the other reviewing safeguarding supervision for Health Visitors.

16) Private Fostering

The work from the HSCB to support the awareness raising has continued throughout 2017 and 2018.

An annual review of private fostering was reported to the Board. The number of cases reported remains low. The report demonstrated considerable activity within Children Social Care to ensure that professionals, agencies and the community understood private fostering and knew how to report it but and there was concern that more of the same activity would not achieve better results. Therefore, the focus on promotion changed to professionals and away from the community. The Board supported the identification of Private Fostering Champions in all agencies including Housing, Police, Health and Education. A bespoke page was developed on the HSCB website and a week of activities is being jointly planned between the HSCB and Private Fostering lead in the hope that driving up awareness with professionals will result in an increase in referrals.

17) Safeguarding Awareness in the Wider Community, Faith Groups, Voluntary and Community Sector

Hounslow has an active and diverse voluntary and community sector (VCS) which is made up of more than 90 not for profit organisations. The HSCB has committed to enhancing the relationship between the Board, the VCS and, the Faith and Community Sector to promote safeguarding. The Board benefits from having a representative from the Hounslow Voluntary Sector as a member of the Board and its sub-groups.

During the Safeguarding week, volunteers from the Board targeted several schools across Hounslow and were able to reach over 600 parents to raise awareness of child safeguarding issues. The CSE and CSA work undertaken outside of statutory services has increased the awareness in the local community and the voluntary and faith sector, evidence of which is noticeable with referrals being made to Children's Social Care.

18) Voice of the Child

In last year's annual report, the Board recognised that it had not consistently sought the voice of the child through its work and in turn had identified it as a key priority area of improvement. As highlighted throughout this report considerable progress has been made throughout 2017 to include the voice of the child in the Boards activities. The voice of young people is particularly evidenced in the ongoing work of CSE and FGM, emerging work on CSA, targeted work in neglect and directly in the work achieved with FYOI. The child's experience has also been considered when reviewing the work of the MASH.

In a step to strengthen the involvement of young people further and incorporate their view as a systematic approach to shaping the Boards work the voice of children and young people has been included in the core business of the 3-year business plan.

19) Conclusion

The overall conclusion is that the HSCB has achieved the aims set out against its 2016-18 priorities and it's now in a strong position to achieve its business plan objectives set out in its 3-year business plan.

The outcomes of the quality assurance work undertaken in 2017-18 has shown signs of significant impact, particularly the focussed work in the MASH, on neglect and in FYOI. Some areas of work, such as the completion and analysis of the dataset is still not yet fully embedded and will continue to be an ongoing core task for the Quality Assurance and Performance sub-group.

During the JTAI Inspection, Ofsted inspectors commented on the strong partnership working in Hounslow to support children and victims of Domestic Abuse, praising the work of the Let's Talk programme. There is solid engagement across strategic partnership Boards and a priority for the next year will be to continue to build on the cross-cutting partnership work to take forward further developments and extend the learning and development programme.

The HSCB learning and development function has supported the delivery of the targeted priority areas, particularly in relation to CSE and the development work of CSE in addition to the delivery of the core multi-agency training for HSCB.

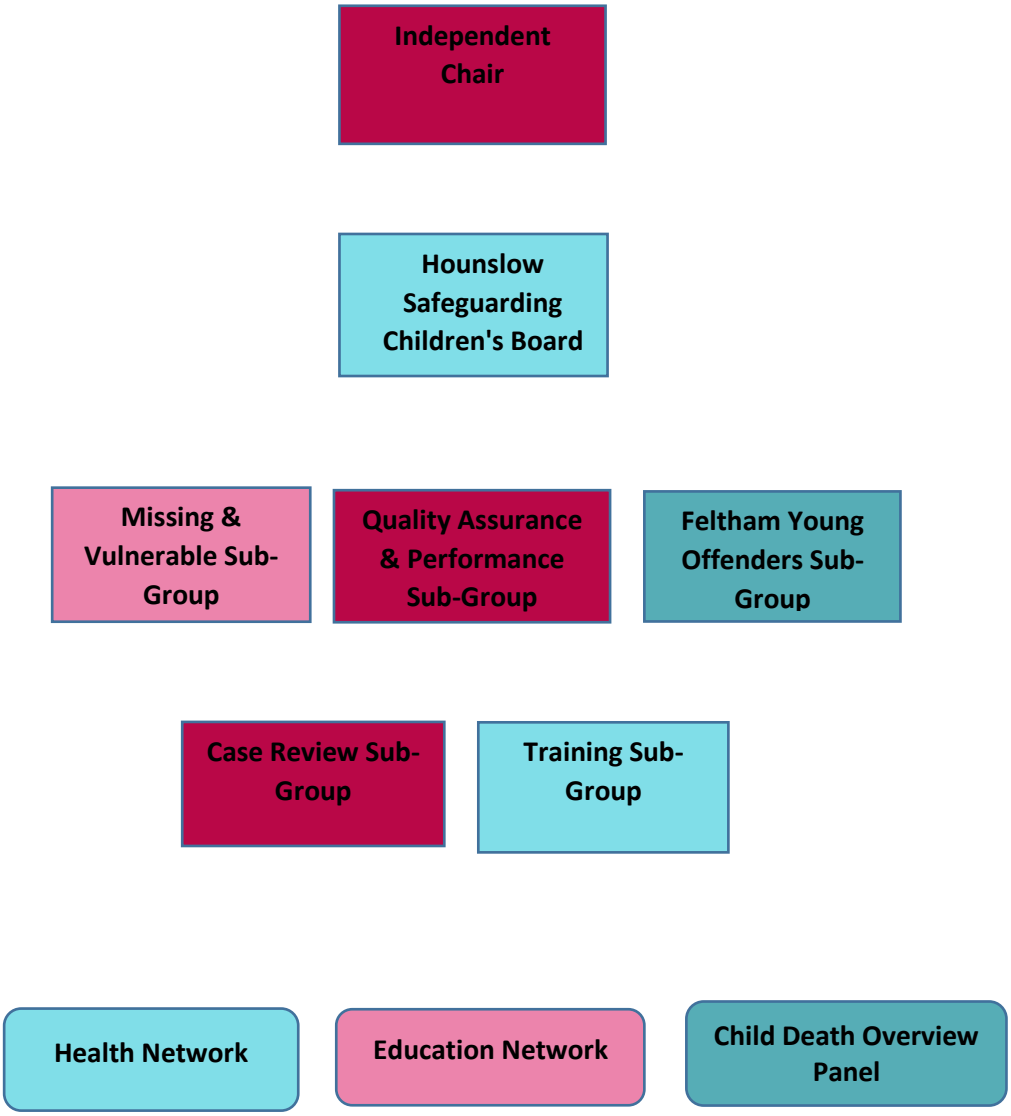
A continued priority of scrutiny is the implementation of the Early Help strategy and to seek assurance that the MASH 'front door' to services is working effectively. Whilst the JTAI inspection of MASH confirmed that thresholds for referral and assessment are appropriately applied, there is a steady flow of new managers, practitioners, teachers, health staff and volunteers contacting the MASH that require information, guidance and training. The scrutiny of contact and referral trends will continue to provide assurance to the HSCB that thresholds are applied appropriately by all agencies alongside an audit of the quality of CFAN referrals made by partner agencies. Similarly, scrutiny of CSE and the MASE will continue to be governed by the HSCB.

The HSCB has focused on specific development areas around neglect and CSA and both will continue in the year ahead. A further development area is the engagement with children and young people and work has started on rolling out an engagement model for the HSCB to become clearer about local needs and to influence the work undertaken by the local safeguarding partnership.

The HSCB will continue to build on its progress in the last year alongside an ambitious programme of work to deliver is 3-year business plan 2018-21. Safeguarding challenges are becoming increasingly difficult and complex to manage for those at the frontline of practice and the Board and its sub-groups will continue to seek assurances, embed learning and strengthen quality assurance processes to ensure it can better understand the profile of safeguarding in Hounslow and demonstrate the impact it has in the safeguarding of our children.

Appendix A

Structure of the HSCB



Appendix B

HSCB Board Membership and Attendance April 2017 - March 2018

Representing	Name	Title	Attendance
HSCB	Hannah Miller	Independent Chair	5/5
Local Authority	Mary Harpley	Chief Executive	4/5
Local Authority	Alan Adams	Executive Director Children's, Housing, Adults'	2/5
Councillor	Tom Bruce	Portfolio Holder for Children's Services	4/5
Lay Member	Bhupinder Lakanpaul	-	3/5
Children's Social Care	Jacqui McShannon	Director of Children's Specialist Services	4/5
Children's Social Care	Lara Wood	Head of Safeguarding & Quality Assurance / Chair of Missing & Vulnerable Sub-Group (December '17 – Present)	4/5
Children's Social Care	Jennifer Hopper	Head of Troubled Families / Chair of Missing & Vulnerable Sub-Group (August '16 – November '17)	2/5
Children's Social Care	Martin Forshaw	Head of Safeguarding Specialist Services	4/5
Education	Michael Marks	Director of Education & Early Intervention / Chair of Education Network	5/5
Education (Primary School)	Debora Kane	Headteacher	0/5
Education (Secondary School)	Ray Whyms	Assistant Headteacher	4/5
Education (College)	Graeme Baker	Executive Director of Performance, Development and Student Experience	2/5
Youth Offending Service	Chris Domeney	Head of Youth Offending Team / Chair of FYOI Sub-Group	5/5
Public Health	Dr Imran Choudhury	Director of Public Health / Chair of CDOP	1/5
Community Safety	Permjit Chadha	Community Safety Manager	5/5
Housing	Amanda Lowes	Head of Housing Client Service	1/5
CCG	Judy Durrant representing Jonathan Webster	Assistant Director for Safeguarding representing Director of Quality, Nursing & Patient Safety – Left in July 2017	1/5

CCG	Dr Nirmala Sellathurai	Designated Dr for Safeguarding Children	3/5
CCG	Julie Hulls	Designated Nurse for Safeguarding Children / Chair of Health Network	5/5
CCG	Sue Pascoe (Covering Judy Durrant)	Associate Director for Safeguarding, CCG	1/5
HRCH	Tony Bowen / Jane Bennie	Named Nurse for Safeguarding Children	5/5
CLCH	Trish Stewart	Head of Safeguarding Children	1/5
CLCH	Amanda Harper	Named Nurse for Safeguarding Children	5/5
WLMHT	Dr Johan Redelinghuys	Director of Safeguarding / Chair of Cases Sub-Group	4/5
WLMHT	Monica King	Named Nurse for Safeguarding Children	4/5
Chelwest Hospital	Hannah Rogers	Consultant Midwife	2/5
Chelwest Hospital	Tony Neville	Director of Nursing, Safeguarding Lead	1/5
London Ambulance NHS Trust	Stewart Critchen	Representative	0/5
IHear	Kylee Brennan	Service Manager	3/5
Police CAIT	DCI Sebastian Florent	Detective Chief Inspector	0/5
Police Borough	DCI Helen Flanagan	Detective Chief Inspector / Chair of Quality Assurance & Performance Sub-Group	5/5
Feltham Young Offenders	Sharon Pearce / Gary Dixon	Head of Safeguards	3/5
National Probation Service	James Jolly	Head of Service for Hounslow, Richmond and Kingston	3/5
London Community Rehabilitation Co'	No Named Representative	-	0/5
NSPCC	Tahira Rauf	Service Manager	0/5
Voluntary Sector	Margaret O'Conner	Homestart Hounslow	1/5
Adviser to the Board	Jo Leader	Acting HSCB Business Manager	5/5
Adviser to the Board	Janet Johnson	HSCB Training & Development Manager	3/5
London Fire Brigade	Greg Ashman	Borough Commander	2/5
CAFCASS	Marcia Lennon		1/5

Appendix C

HSCB Budget April 2017 - March 2018

Annual Income	
Children Services Base Budget Contribution.	£147,000
CCG	£20,000
Public Health (CDOP Contribution)	£18,000
Police	£5,000
Early Years	£4,000
CAFCASS	£550
London Fire Brigade	£500
Total	**£195,050.00**

Expenditure	
Employee Costs *(Acting Business Manager, Training & Development Manager, Agency Business Support & Development Officer)*	£125,689.75
HSCB Activity	
CDOP Function	£5,280
Independent Chair	£23,075
Serious Case Review	£3,450
Quality Assurance Activity	£6,000
Board Development Activity	£1,625
Training Spend	
Events / Catering / AV Services / Training Materials / Virtual College Registration System	£6320.50
Commissioned Training	£3,600
Total Board Expenditure	**£175,040.25**

Appendix D

Case Learning Log

LOCAL CASE LEARNING DISCUSSIONS				
Case	**Theme**	**Outcome**	**Learning**	**How the learning was used**
Case 1	Historical Sexual Abuse	Closed - thematic points of learning identified	Confidence by workforce to explore sexual abuse	Incorporated into Familial Sexual Abuse training seminar CSA Prevention Plan updated Incorporated into CSA training need analysis
Case 2	CSE / Missing	Closed – thematic points of learning identified	Multi-agency meeting at Hospital picked up on links between CSE and missing alerting CSC. System worked well to share information	-
Case 2	Non-accidental injury	Closed – local learning identified	Family resistance to support. Over reliance on other services Judgements made for non-verbal and non-mobile children Multi-agency communication through safeguarding processes.	Change to supervision processes. Refresher training in health services. Protocols revised. Management oversight process improved.
Case 4	Suicide	Closed – Local learning identified	Professionals worked well together and incident was not preventable	Included in broader consideration of suicide in Hounslow and Suicide Strategy
Case 5	Suicide	Progressed to Serious Case Review	Ongoing	Not started
Case 6	Transient Family / Domestic Abuse	Closed – thematic points of learning identified	Consistent ICPCC & CGM Consistent use and understanding of terminology re physical abuse.	Core group and safeguarding multi-agency training updated. Cultural and diversity considered in all

			Scope for multi-agency decision making in criminal investigations Consideration of cultural and diversity factors early in cases.	quality assurance activity for the HSCB.

National Case Reviews			
Case	**Theme**	**Learning**	**How the learning was used**
K&C SCR	Baby Rose	Management of mental health in A&E Escalating risk to Police and appropriate agencies when they are significantly concerned Use of adequate language to express the concern	Assurance requested from local hospital to ensure appropriate practices are in place to support learning from review.
Yasmine / Olivia SCR & Carol SAR	Looked After Children Vulnerable Adult Cuckooing ASB Murder	Disjoint between services working with vulnerable children and a vulnerable adult. Single track thinking. Missing opportunities to work together. Seeing problems and not thinking of vulnerability.	Joint seminar between HSCB, HSAB and CSPB for 2018.
-	Trauma Led Practice	Theme in many cases reviewed of trauma led practice and chronic neglect.	Work to be taken forward in 2018 by Training Sub-Group.