13 June 2017

Alan Adams , Director of Children's Services, Hounslow council
Jonathan Webster, Director of Quality, Nursing & Patient Safety, Hounslow CCG,
Sophie Linden, Deputy Mayor for Policing and Crime
Cressida Dick, Commissioner, Metropolitan Police Service
Chief Supt Raj Kohli, Borough Commander, Hounslow MPS
Chris Domeney, Manager, Hounslow Youth Offending Team
Kilvinder Vigurs, National Probation Service Director, London Division
James Jolly, Head of Hounslow, Richmond & Kingston Probation Service
Helga Swidenbank, Director of Probation, London Community Rehabilitation Company
Katrina D'Austin, Child Safeguarding Lead, London Community Rehabilitation Company
Hannah Miller, Chair, Hounslow LSCB
Sarah Parsons, Assistant Director, Cafcass

Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in Hounslow

Between 21 March 2017 and 24 March 2017, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to abuse and neglect in Hounslow.[1] This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Hounslow.

The inspectorates recognise the complexities for agencies in intervening in families where there is more than one victim and where, as a consequence, risk assessment and decision making has a number of complexities and challenges, not least that the impact on the child is sometimes not immediately apparent. A multi-agency

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

inspection of this area of practice is more likely to highlight some of the significant challenges to partnerships in improving practice. We anticipate that each of these joint targeted area inspections (JTAIs) will identify learning for all agencies and will contribute to the debate about what 'good practice' looks like in relation to children living with domestic abuse. In a significant proportion of cases seen by inspectors, there were risk factors in addition to domestic abuse, which reflects the complexity of the work.

Reducing incidents of domestic abuse is a key priority for the police and the local council. Prioritisation of domestic abuse has led to some good and excellent services being available to families where children have experienced domestic abuse. However, insufficient performance information and evaluation do not support effective strategic planning. There is an over-reliance on the police and social care and, when there are shortfalls in practice, other partner agencies do not escalate their concerns.

Effective multi-agency working by frontline practitioners in Hounslow leads, in the majority of cases, to improvements in the day-to-day lives of children living with domestic abuse. There is evidence of purposeful child-centred direct work with children and their families, who are safer as a result. The availability and impact of interventions, for example 'Let's Talk' (a programme for children to support their recovery from having lived with domestic abuse), and the deployment of child and adolescent mental health service (CAMHS) staff in the West Middlesex University Hospital (WMUH) are making a real difference in giving children and young people a voice. The police have taken decisive action to ensure that, when called to incidents, they speak to all the children in the household. In the national probation service (NPS), risks posed by perpetrators are identified and promptly referred to the multi-agency risk assessment conference (MARAC). In stronger cases, there are examples of tenacious, culturally sensitive work by partner agencies.

Some good work was seen by inspectors. There were a number of areas for development in relation to the multi-agency safeguarding hub (MASH). The potential benefits of multi-agency working in the MASH have not yet been fully realised. When deficits were identified in the MASH, the council took swift action to ensure that children were receiving the appropriate service, and actions have been developed to further improve the MASH. In addition, there are specific areas for improvement across the partnership and for individual agencies. Most of these areas for development had already been identified by the partnership, and work is taking place to make improvements. The council leads a strong culture of openness and learning. The foundations are in place to further improve the response to children living with domestic abuse in Hounslow, with continued prioritisation of resources in this area of practice.

Key Strengths

- The Hounslow One Stop Shop is an excellent service. Parents who are subject to domestic abuse are able to attend this resource, which is open one morning a week, and they can access a wide range of support, advice and signposting to services. Parents can access legal advice, support from an independent domestic violence adviser (IDVA), children's social care, police, housing, substance misuse support, a refuge worker and an independent sexual violence adviser. Parents are gaining an understanding of the impact of living with domestic abuse, leading to their being better able to meet the needs of their children and keep them safe.
- The MARAC arrangement in Hounslow is strong, and a broad range of services contributes to information sharing and joint plans to protect victims of domestic abuse and their children. The multi-agency focus on domestic abuse is improved by the IDVA delivery service manager, providing an effective link between multi-agency public protection arrangements (MAPPA) and the MARAC.
- Evidence was seen of performance monitoring by the Hounslow Safeguarding Children Board (HSCB) leading to improvements. For example, analysis of performance information identified low referral rates to the MARAC by social workers. Appropriate referrals are now being made in a more timely way, due to the development of mandatory training, which is building the confidence and knowledge of social workers in this area. Though some progress is being made, more work is needed to ensure that health providers consistently make referrals to the MARAC when the threshold is met.
- Core groups are effective in progressing child protection plans and reducing risk. The involvement of family members, including the extended family, has supported more effective communication between agencies and families and improvements in the day-to-day experiences of children.
- Good raising of awareness of domestic abuse is demonstrated through the learning to respect domestic abuse education programme in schools. Hounslow has gained white ribbon status (a campaign to stop male violence against women and girls), which has been used to raise awareness further.
- Parents spoken to by inspectors were very positive about the 'Let's Talk' programme that supports children who have lived with domestic abuse. Creative work is undertaken with children to enable them to understand their experiences of living with domestic abuse. Work is also undertaken with adult victims, which enables them to better support their children.
- Good prioritisation of reducing incidents of domestic abuse has led to a range of effective projects. It is positive that a domestic violence intervention project has been commissioned by the local authority. However, there is more work to do to engage perpetrators in this programme.

- The 'Families First' team works with families that do not meet the threshold for children's social care. The quality of assessments, safety planning and direct work in this service is strong. Staff use evidence-based interventions to work with families, and progress is measured. Good therapeutic work with children takes place, and families access appropriate support and services, which leads to a reduction in risk and to children's needs being met.
- All staff spoken to in children's social care reported that they feel well supported by their managers, receive regular supervision and feel that concerns about their own safety are acted on. As a result, they feel safe to challenge parents. They reported that regular training is provided and that they feel confident and skilled in undertaking this complex work.
- The majority of assessments undertaken by social workers are comprehensive, are updated regularly and include information from other agencies. They are analytical and evidence based. Assessments record the child's voice and focus on the day-to-day lived experience of the child. Risks and strengths are robustly identified, and there is evidence of respectful, culturally sensitive challenge.
- Management oversight of practice is strong in most cases seen in children's social care. Monthly reflective group supervision sessions led by the advanced practitioners support effective practice.
- The council has driven an open and learning culture. Social workers have good access to support, training and supervision. An emphasis on social workers undertaking direct work with children and their families was a consistent feature of the cases seen. This approach has supported the retention of staff, and social workers are positive about working for Hounslow council.
- The youth offending team is working effectively with partners to identify the risk of children experiencing domestic abuse, and appropriate plans have been put in place to reduce risk. The service undertakes good work with young people who have experienced domestic abuse.
- The Metropolitan Police Service in Hounslow has demonstrated a commitment to improvement in some areas by eradicating the backlog of domestic abuse incidents requiring a police response in the borough of Hounslow. This means that children living with domestic abuse receive a more timely response.
- In almost all of the incidents attended by frontline police officers, the voice of the child is gathered and recorded. The police demonstrate an understanding of how domestic abuse affects children. They are engaging with children, making observations on factors, including the environment where they are living and their demeanour, and checking their physical welfare.
- Perpetrators of abuse are arrested in a timely way, and the police prioritise safeguarding children and the adult victim.

- The Metropolitan Police Service has established Operation to Dauntless and Dauntless Plus. The impact is that plans have been put in place to mitigate the risks presented by the highest-risk domestic abuse perpetrators. These plans are managed through daily meetings to ensure consistent oversight.
- Notifications under Clare's Law (right to know, right to ask)[2] have increased slightly in Hounslow. This is positive and supports the mitigation of risk related to domestic abuse incidents and harm to children.
- The implementation of Operation Encompass[3] shows a commitment to working in partnership and sharing information with schools about children living with domestic abuse. It is too early to identify impact.
- The Hounslow Safer Homes Sanctuary project offers advice on and support to practical changes to make properties more secure. This has led to some victims of domestic abuse and their children being safer.
- Health services effectively identify risk to children as a result of domestic abuse. They make good-quality, prompt referrals, which clearly identify the risks to children. For example, the maternity services use a domestic abuse screening tool that supports midwives to talk to women who may be living with domestic abuse.
- Women at risk of domestic abuse who use acute health services benefit from the accessibility of an IDVA. The IDVA is highly visible and accessible across all health services. This has led to better knowledge and understanding of domestic abuse among health staff, and improved both the recognition of and the response to families.
- The location of the adult substance misuse service, iHEAR, within the WMUH emergency department is a strength, as it means that services are accessible to families. The focus on children and the risks that adults may pose to them through the 'Think Family' approach is leading to robust, family-focused assessments.
- There are examples of excellent safeguarding work in the identification of domestic abuse and the understanding of its impact in the family nurse partnership[4]. Risks to young women who are pregnant or who have young children are identified so that families are appropriately protected.
- Regular multi-agency pre-birth meetings take place to discuss current cases in which there are safeguarding concerns and referrals made by the maternity unit.

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[2] Clare's Law - A disclosure under this scheme is the sharing of specific information about an individual with the person making the application or a third person, for the purposes of protecting a potential victim from domestic violence.

[3] Operation Encompass is a project whereby schools are informed by the police of incidents of domestic abuse that relate to their pupils.

[4] The family nurse partnership undertakes voluntary home visits to first-time young mothers, aged 19 years or under.

This provides a good opportunity for operational oversight of risks that relate to pregnant women and supports good care and safety planning for vulnerable women and their unborn children.

- CAMHS practitioners from the West London Mental Health Trust (WLMHT) provide a comprehensive service to paediatric wards and the emergency department, which leads to young people who have emotional and mental health issues and who live with domestic abuse receiving timely and effective support. They also provide oversight of 16- and 17-year olds who elect to be admitted to adult wards. There is a dedicated bank of mental health nurses who provide permanent coverage in the hospital, the sole purpose of which is to routinely support young people in mental health distress on a one-to-one or two-to-one basis. This is good practice.
- Families living with domestic abuse are able to access timely family therapy through CAMHS, which supports a reduction in risk and better understanding by parents of the impact of domestic abuse on their children.
- Training arrangements across health providers are generally strong, with the exception of adult mental health. Practitioners told inspectors that they have access to multi-agency training from their own agency and also from the Local Safeguarding Children Board (LSCB). Training includes domestic abuse, honour-based violence, child sexual exploitation and female genital mutilation. This enables frontline practitioners to be better aware of how to recognise and respond to children living with domestic abuse.
- Safeguarding supervision within the health visiting service, school nursing service and iHEAR is good. Operational management oversight of cases in which there are safeguarding concerns is strong.

  The collaboration of five clinical commissioning groups (CCGs), which includes Hounslow, is a strength, particularly in relation to sharing of information and learning, which positively impacts on the safeguarding of children. The CCG undertakes work to identify strengths and weaknesses in relation to safeguarding children, including the quality of referrals made to children's social care. This ensures that children identified as living with domestic abuse are appropriately referred to the MASH.

Case study: highly effective practice

One exemplary case concerning young children demonstrates strong multi-agency working. Following the referral from school, the protection of the children was prioritised. The assessment provides good analysis of risk and strengths. There is evidence of culturally sensitive, respectfully challenging work with the family to address the experiences of children living with domestic abuse. Direct work with the children by the social workers and through the 'Let's Talk' programme provided significant help and support to the children and the adult victim in understanding the impact of the abuse. The mother has been empowered to challenge cultural and gender stereotypes within the family and was able to gain employment outside the home. Agencies have fully involved the extended family in supporting all family members. This enabled the father to continue to live with them while he completed a perpetrators' programme delivered one to one by his probation services officer, from the National Probation Service. The children's views and needs were fully considered and informed decision-making. Changes are being sustained, and the risks have been significantly reduced. The children's day-to-day experience has improved significantly. The mother stated:

'*It was scary in the beginning. Me and my children didn't believe what had happened and what would go on to happen. With the help of all those professionals, my husband and me came to understand how we must look after our children. It's all made such a difference. Through the process, my husband has learned to understand our children and how, as they grow up, they have a right to express themselves and be listened to when they have an opinion. He better understands my feelings too and when I ask him to listen to me he does now.'*

Areas for improvement

Identifying and managing risk of harm at the 'front door'

- Thresholds are not yet consistently well understood or applied. Some partners report that they have to make several contacts before a contact is progressed. In addition, partner agencies send inappropriate and irrelevant information, which generates work and blocks the system. This has been recognised, and work is taking place to improve the understanding of thresholds.
- Good commitment from agencies across the partnership to provide a multi-agency approach to information sharing has led to a MASH that includes health, police and social care professionals who are co-located. However, there is insufficient management oversight and performance monitoring. This has led to inappropriate decisions to take no further action in a small number of cases in which it was reported that children were living with domestic abuse. There is a lack of a clear rationale for these decisions. The council has taken swift action to ensure that children are receiving an appropriate response. There are clear actions in place to improve the effectiveness of the MASH.
- The roles of the MASH and professionals from different agencies within the MASH are insufficiently clear. Effective dialogue and joint decision-making do not take place. Health partners are rarely involved in decision-making. The full potential to improve information sharing and decision-making through multi-agency working has not yet been fully realised.
- There is a timely response to information requests from most partners, and the majority of delays are due to health partners. Work is being undertaken to improve the timeliness of response from health partners, and there is evidence of improving timeliness in sharing information.
- Agencies are not informed of the outcome of contacts and referrals and are not proactive in obtaining this information, which means that they do not know whether the case will progress to a social work assessment or whether the case has been signposted to other services or closed.
- The threshold for strategy discussions in domestic abuse cases is not consistently recognised, and this leads to delays in information sharing and joint decision-making. Strategy discussions are usually held between the police and children's social care and do not usually involve health or other key partners, which does not enable effective information sharing about risks and strengths to support robust decision-making.
- There is insufficient use of performance information by the MARAC to understand the effectiveness of interventions for families. For example, the number of times a victim is referred to the MARAC is not considered.

- In some cases, there is insufficient focus on the assessment and intervention of perpetrators by agencies.
- The partnership needs to consider how to build on the excellent work with younger children when parents have separated, and how to more effectively support older children who are living with domestic abuse and children whose parents continue to live together. The voice of older children is not as strong as that of younger children, and support is not as robust.
- There is an over-reliance on children's social care and the police, and when there is a shortfall in practice others agencies do not challenge. This means that concerns are not escalated, and there is a lack of proactivity when partners do not receive sufficient information about a referral that they have made or are not sufficiently engaged in information sharing or decision-making.
- Performance monitoring by the community safety partnership of children living with domestic abuse is underdeveloped. There is insufficient monitoring of the effectiveness of responses and interventions to children living with domestic abuse. This does not effectively support strategic planning and service development. Measures of success have not been determined, which means that progress cannot be effectively monitored or challenged. As a consequence, the partnership does not yet fully understand the profile of children living with domestic abuse.
- The LSCB has not received sufficient information to enable it to effectively evaluate, challenge and monitor the MASH, early help and the response to children living with domestic abuse. There is also insufficient clarity on what success looks like. There have been some very recent improvements in the information that the Board receives and the level of challenge.
- Insufficient social work capacity leads to some caseloads being too high and some delays in assessments being completed. The council is addressing this by increasing the number of social work posts.
- The lack of effective chronologies in children's social care and the health visiting service does not support professionals in identifying risks through the consideration of significant events and historical information.
- Some frontline police officers are assessing risk in isolation, concentrating on the incident that they attend rather than a more holistic approach that considers vulnerability, history and environment. In a significant number of cases, the risk is assessed inappropriately as a standard risk and is therefore not prioritised. This means that full information and risks are not shared, which does not enable effective prioritisation and a timely and appropriate response.
- In some of the cases examined, it was evident that there are difficulties experienced in communication between police departments, across police boroughs and with partner agencies. The different management structures for the locally based police community safety unit (CSU) and the central child abuse

investigation team (CAIT) lead to a disjointed response for children living with domestic abuse. The proposed implementation of a new protecting vulnerable people (PVP) structure, planned for early 2018, will draw together the CAIT and the CSU under the same line management and should, therefore, provide a more coherent approach to risk management. However, there is no plan to manage the interface between the CAIT and the CSU before this.

- There is insufficient use of domestic violence protection notices/orders by the police to improve safeguarding. While they are considered in most investigations, other demands on resources limit both their use and their proactive enforcement when they are deployed.
- When there is a report of a non-crime domestic abuse incident, if the victim cannot be contacted there is a lack of consistency in reassessing the risk. This could result in a delay of a number of days before a victim and their children are seen by a police officer and, thus, a potential delay in appropriate action being taken to safeguard the victim and/or their children.
- Quality assurance and auditing of the work undertaken by the police are underdeveloped. This means that the police do not have sufficient information to evaluate their service and to inform developments at both practice and strategic levels.
- Low staffing levels in the CAIT are impacting on the team's ability to respond effectively to the safeguarding of children.
- General practitioners (GPs) are not sufficiently involved in the MARAC process. This is recognised by the partnership, and a process is about to be implemented to support more effective information sharing between GPs and the MARAC.
- There is a lack of participation in core groups and child protection conferences by adult mental health professionals when they are involved with a family member. This means that assessment and planning are not sufficiently informed about the impact of an adult's mental illness on their parenting capacity and about the assessment of risks and strengths in relation to caring for their children. In addition, no professionals from adult mental health currently attend the MARAC, which does not support effective information sharing and decision-making.
- The current arrangements for the use of the common electronic patient records system in GP surgeries and community health teams are ineffective. Practitioners are recording information on different systems, so the full information about a family is not always accessible to each health professional, which means that risks to children are not always fully assessed. Systems for alerting staff to concerns are also inconsistent. In addition, liaison between community child health teams, comprising, for example, health visitors, school nurses and GPs, is significantly underdeveloped. Multi-agency meetings do not usually take place when risks to children have been identified. This, combined with the ineffective

recording system, results in information not being effectively shared and risks not always being fully identified.

- Lack of management oversight leads to variation in the quality of referrals sent to the MASH by the London Community Rehabilitation Company (CRC) and the NPS. This does not support effective information sharing and decision-making for children and their families.
- The NPS does not undertake checks with children's services when reports are produced for adults in court on the day of sentence. This could mean than an offender who poses a risk to children is given a custodial sentence and could continue to pose risks while in prison. Insufficient awareness of these risks means that plans to protect children are not always in place.
- The CRC's provision of interventions to address domestic abuse does not consistently reduce risks posed by perpetrators in a timely way. There are long waiting lists for the Building Better Relationships programme[5]. Some service users have re-offended before being able to start the programme. The CRC is yet to provide domestic abuse interventions for those ineligible for this programme. This means that some offenders will finish their sentences without completing relevant work to lower the risk of their harming.
- Not all the NPS and CRC staff have completed their mandatory child safeguarding training. Insufficient training of staff is a particular weakness for the CRC: staff do not have sufficient knowledge and skills to understand the impact and risk to children living with domestic abuse.
- Communication between the CRC and children's social care is not good. The CRC is not consistently invited to multi-agency meetings where its involvement would enable more effective assessment and intervention. There is also a lack of involvement with partners by the CRC at a strategic level. For example, the CRC does not participate in the HSCB.
- A shared proactive approach to planning and responding to the housing needs of vulnerable families, including children living with domestic abuse, is not yet in place. This can mean that some families live in inappropriate housing for too long, which exacerbates the risk. Unplanned responses can result in children living with domestic abuse being placed in emergency accommodation, such as bed and breakfast accommodation.

[5] The Building Better Relationships programme is an accredited group work programme for men who have been violent in their relationships, which can be imposed as part of a sentence.

Case study: area for improvement

In a small number of cases, there is a lack of effective assessment and decision-making in the MASH in relation to children who are living with domestic abuse.

The MASH received a contact from a school that stated that a young child had reported that there had been a serious incident of domestic violence in the family home the previous night. The risk was not fully recognised, which led to a lack of prioritisation.

The MASH tried to contact the mother, without success. The decision was to take no further action. The school was not contacted for further information, checks with other agencies were not completed and there was a lack of recognition of the risk to the child and their day-to-day lived experience. A second contact was subsequently received from the school, and there were additional concerns about the presentation of the children. Risk, again, was not fully recognised, and this contact was insufficiently prioritised.

Next steps

The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the NPS, the CRC, CCGs and health providers in Hounslow and the Metropolitan Police Service.

Yours sincerely

Ofsted	**Care Quality Commission**
 Eleanor Schooling National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Alan MacDonald Assistant Chief Inspector