Redbridge LSCB Local Safeguarding Children Board

Independent Chair: John Goldup

KEY FINDINGS AND LEARNING FROM MULTI-AGENCY AUDITS 2016 – 2017

Introduction

A total of four of multi-agency audits were carried out by the LSCB Multi-Agency Audit Working Group during 2016 – 2017. Each audit was linked to one of the priorities of the LSCB Business Plan 2016 - 2017, all using a specific Key Line of Enquiry (KLOE) and audit tool. Each audit considered between 6 and 10 cases, all of which had a wide range of multi-agency input. Summary reports on each audit, including recommendations, were presented to the LSCB Learning and Improvement Sub Group and learning disseminated through multi-agency briefings as part of the LSCB Training Programme 2016 – 2017.

Early Years Multi-Agency Audits	10 cases audited.	Completed August 2016
The purpose of the audit was to further promote effective multi-agency working, to identify best safeguarding practice in early help in early years and address any areas of improvement between children's centres and other departments within the local authority/ partner agencies.		

Children with Disabilities (CWD)	6 cases audited.	Completed September 2016
Business Plan Priority 4: To strengthen the safeguarding of children with disabilities, and to reduce the incidence of disability by increasing awareness of the risks of consanguineous relationships.		

CSE/MASE	8 cases audited.	Completed December 2016
Business Plan Priority 1: To improve the protection and support of children who are at risk of, or who have been, sexually exploited, and to strengthen our work in identifying, disrupting and prosecuting child sexual exploitation (CSE).		

Families with Multiple Needs: Parental Mental Ill-Health, Domestic Abuse and Substance Abuse	8 cases audited.	Completed February 2017
Business Plan Priority 2.5 To improve the protection and support of children living with domestic violence, substance abuse, and adult mental ill-health.		

Key Findings and Learning

Below are the key findings and learning from each multi-agency audit for use in training and other learning and development activities.

Early Years Multi-Agency Audits

The purpose of the audit was to identify best safeguarding practice in early help in early years and address any areas of improvement between children's centres and other departments within the local authority/ partner agencies.

Findings:

- In 100% of the cases early help needs were correctly identified by children's centres using a Common Assessment Framework (CAF) at the earliest opportunity and made referrals to other agencies/ services where appropriate within timescales specified in the CAF/Team Around the Child (TAC) action plans.
- In 100% of the cases the referral was appropriate for the service it was referred to.
- The data sharing was very effective between the Children's Centre and the services they involved and were responding to information/ data requests by Children's Centre.
- Multi-agency meetings were set up to enable a range of key partner agencies/ departments to focus on working together in a more integrated way to improve the quality of early help for vulnerable children and families and to prevent any child falling through the net.
- The professional invited to TAC meetings was dependant on the lead professional, being made aware of services working with the child/family. Children's Centre staff did always seek information via the CAF Team (for information available on Protocol) and the Health Visiting service.
- The Children's Centre's knowledge was dependant on the willingness of partner agencies/ services to provide information to them as they had no direct access to any database such as Protocol, RIO etc. Thus, some services were not aware of there being a CAF and or TAC. However, in some cases it was also found that, despite Children's Centre staff repeatedly inviting services to engage in the TAC process, they were not coming forward.
- In 100% of the cases the Children's Centre Family Support Workers recorded the voice of the child through their observation and where appropriate they also recorded observation of partner agencies, such as nurseries, in the CAF and TAC documents.
- In 100% of the cases, the CAF audits evidenced that as a result of early help, with children's centres as the lead professional, there was an improvement or a significant improvement on the Family Outcome Scales, evidencing a positive outcome and impact for the child and the family in each case.

Learning/Recommendations:

- There is clear evidence that the partnership working approach that the children's centres facilitated had a positive impact on the development of the young children through the early help provision in Redbridge. Through effective the use of the CAF children and families received planned support and provision that lead to reducing the risk of harm to children and greatly improved family life in each case.
- Any organisation/ service working with a family where there is a child under 5 should check if Children's Centre is already working with the family. If the family is not already known to a Children's Centres, the family should be registered with the Children's Centres by that service or refer to the child's local children's centre by using the Children's Centres referral form or by other written mechanism. This is to ensure that the family has given consent and relevant information is shared with the CC.
- Children's Centre Group Leads would benefit from having an appropriate level of access to Protocol and Early Help recording systems.
- All agencies involved in delivering support to a child via the CAF process should attend TAC meetings where possible. Where it is not possible then information should be shared with the Lead Professional in Children's Centres in advance of the meeting.

Children with Disabilities (CWD)

- There is an underrepresentation of children with disabilities who are subject to a Child Protection (CP) Plan within Redbridge. As at July 2016, there were 2191 open cases to LBR children's social care, of which 437 are children with disabilities. This is a high proportion (19.9%) of all open cases. However, only 12 of a total of 321 children who are subject to a CP Plan have a disability, which is only 3.7% and significantly out of proportion.
- This leads to scrutiny as to why, and are children with disabilities being safeguarded effectively? It was important to carry out a multi-agency audit to establish if children with disabilities are safeguarded effectively as well as to disseminate any learning identified.

Findings

- Overall information sharing and working together was good. Agencies seemed to share the appropriate information in a timely manner.
- There was evidence of some good work in relation to the voice of the child across agencies. In the majority of cases individual work with the child, their views, wishes and feelings had been captured on file. However, this was not reflected in the assessments or Children in Need (CIN) Plans within children's social care. To ensure that this work is meaningful, the voice of the child must be reflected within the assessment process as well as any plans for the child.
- In a sibling group of multiple children with a disability, the voice of the child on the case being audited was very limited as majority of the work focuses on the most severely disabled sibling.
- In the majority of cases audited there appears to be good early identification and prompt responses to safeguarding children with disabilities.
- In the majority of cases audited, plans were not available. In one case the CP Plan did not address the child's needs nor did it make reference to the desired outcome/goals and what the Plan is striving to achieve. One CiN Plan stated clear actions/goals to be achieved but this Plan was not reviewed to agreed timescales. Overall this area of work demonstrated some weaknesses for agencies in creating SMART plans that are reviewed to agreed timescales.

Learning/Recommendations:

- The majority of audits showed that children's needs were identified, multi-agency assessments were carried out, needs were met and timely multi-agency support was accessible and effective.
- The quality of assessments was variable from some very detailed thorough assessments with a good level of analysis, theory and relevant research, to very basic assessments that only identified the most very basic of children's needs with no analysis.
- Police stated that in one case, the child was at the forefront of the investigation but the VoC had not been evidenced in their paperwork or audit.
- It was found that all agencies across all cases worked very effectively with parents/primary carers. Workers appear to have developed good professional relationships with parents/carers resulting in several examples of good outcomes including concerns regarding school attendance being addressed in a timely manner as well as evidence of a difficult safeguarding issues being openly discussed with a positive outcome.
- The quality of care planning, including being 'SMART' and effective in setting out CP concerns, reducing risk and resolving concerns, was variable, with health stating that one particular Care Plan was not sufficiently SMART.
- One case had no CP plan, minutes from CP conference were not available nor was there any mention of a core group being set up. The auditor escalated this case with the Team Manager and the CPAT and it transpired that the work had been undertaken but there had been a delay in uploading the relevant documents to protocol. This was immediately rectified.
- Police stated that they were routinely notified of CP meetings and plans were shared.
- In some cases, assessments were dated and plans had not been reviewed as per timescales highlighted in the social care Child in Need (CIN) procedures.
- Health confirmed that there as good evidence on RiO (health case recording system) of excellent understanding of concerns, liaison and work between CWD Team and Child and Adolescent Mental Health Service (CAMHS).

Child Sexual Exploitation (CSE) and MASE Panel

LSCB Business Plan Priority 1 in 2016-2017 was to improve the protection and support of children who are at risk of, or who have been, sexually exploited, and to strengthen our work in identifying, disrupting and prosecuting child sexual exploitation (CSE). A multi-agency deep dive audit took place followed by an all-day 'round table' discussion which pulled together discussions from a variety of agencies for 8 cases being audited.

Findings

- All agencies were able to evidence effective working together across all 8 cases. Occasionally some agencies did not communicate information as robustly as would have been expected.
- Multi-agency working through MASE has demonstrated its effectiveness and impact in reducing the CSE risks to young people that have engaged in the work of multi-agency partners.
- The MASE panel has been seen to be a very positive process allowing for information sharing and multi-agency challenge. Agencies commented that the MASE panel has become more robust. However, information from MASE (minutes/action points) need to be clear in order for agencies to understand what actions have or need to take place.
- The young people's voices have been heard and recorded by agencies.
- Agencies seemed to work in a more co-ordinated way whilst a child was on a CP rather than on a CiN (Child in Need) Plan.
- Young people seemed to engage more with agencies like Safer London and the NSPCC when exploring their risks and vulnerability to CSE than other statutory agencies involved. Where this was the case, their vulnerability to CSE had decreased significantly whilst gaining a deeper insight into CSE and the risk factors. Outcomes for these young people were positive.
- Where there had been a change/multiple changes in social workers, this has had a negative impact on young people as they find it difficult to develop positive relationships with each new social worker.
- Police investigations were thorough and taking into account the needs and voice of the child.
- All cases appeared to have good management oversight across multi-agency working.
- The majority of Child Protection Plans have been SMART and robust. On one occasion a CP Plan did not address increased vulnerabilities and risky behaviour.
- The YOTPs involvement had a positive impact on a young person who was previously unwilling to engage. As a result of her engagement in this service, she has been referred to other services that have been able to support her.
- BHRUT systems did not flag up the majority of cases audited 'Looked After Children' on their records. This will be rectified by the implementation of their CPIS implementation which is due imminently.

Learning/Recommendations.

- Minutes/notes of MASE panel to ensure accuracy of action points on each case as well as ensuring minutes/actions are distributed to all involved.
- CP and CiN plans to be consistently robust in identifying, addressing and minimising the CSE risk factors. Plans should be updated when there are significant changes in the case that would impact vulnerability.
- The correct specialist services should be identified and commissioned in order to support the young person.
- Police should keep families and professionals updated, where appropriate, on the progress of their investigation and likely delays within the CPS's decisions.
- Social Care should consider the impact of multiple changes of social workers on children at risk of sexual exploitation.

Families with Multiple Needs.

- LSCB Business Plan Priority 2.5 in 2016-2017 was to improve the protection and support of children those living with domestic violence, substance abuse, and adult mental ill-health.

Findings

- In 2 of the 6 cases there was very little evidence of the 'voice of the child' and it was hard for all professionals to gain a sense of the child, it is possible this was due to the age of the children or because these are the cases where disguised compliance was evident. In the other cases all agencies were able to provide insight into the child's lived experience.
- School Designated Safeguarding Leads referred to conversations which assisted them to reflect on the risk factors and how to manage them in a way which they had not considered previously. All the schools who participated in the audit felt that supervision for designated safeguarding leads in schools would be invaluable to work with families and build emotional resilience in education staff.
- Throughout the audits and case discussion a consistent theme occurred: attendees felt more professional curiosity could have been exercised in some of the cases.
- In 4 out of 6 there were significant males in the family not adequately involved in assessments.
- Elements of disguised compliance were evident in all cases.
- Education Welfare reported that not all schools are aware of who their School Nurse contact was, resulting in communication between school and school health not being achieved. In relation to case 3, it was felt this resulted in a delay in social care being made aware of the complexity of issues relating to neglect.
- Child Protection Plans were not SMART in cases 4 of the 6 cases. There were no Child Protection Plans for cases 2 of the children as they were subject to child in need plans.
- Investment in safeguarding within BHRUT has established effective change in assessment, reporting and culture within A&E and improved safeguarding practice.
- In 5 of the 6 cases there was clear evidence of specific agencies (NELFT, Education, Fusion and Refuge) where it was identified that professionals had gone above and beyond, there were positive relationships between the families and the agency and improved outcomes for the children were evident.

Learning/Recommendations

- Specific consideration should be given to evidencing the child's lived experience for pre-verbal children. Attendance by front line staff should be encouraged by all agencies delivering services to children and young people. 'Voice of the Child' should also become a standard agenda item within case supervision.
- Safeguarding Supervision should be available to school designated safeguarding leads.
- Regarding males missing from assessments, the LSCB training programme will be facilitating 'See the Adult, See the Child' sessions in 2017-2018. All professional should include males in the child's life in all assessments.
- Use of assessment tools such as the Neglect Toolkit, should be encouraged by all agencies when completing assessments as part of everyday practise.
- Education Welfare and NELFT should compile an up to date list of all schools within the Borough and their appropriate School Nurses for this to be provided to all education provisions.
- Targeted training to be provided to child protection chairs to ensure the formulation of SMART Child Protection Plans. Child protection chairs to review case files between conferences to ensure actions are being completed in a timely manner. The quality of child protection plans will continue to be tracked via the Chair/Independent Reviewing Officers clinic.
- Child Protection Conference Chairs should reinforce to all members of the Core Group at each Child Protection Conference their responsibility within the CP plan; this includes attendance at core groups, and that partner agencies should request an earlier review, if the plan is not progressing.