CHSCB Quality Assurance Sub-committee

Report on Audit of Safeguarding practice within Tier 2 service provision in Hackney.

Introduction

This report summarises activities undertaken between April and June 2011, by the Quality Assurance (QA) sub-committee to explore safeguarding activity within Tier 2 services and processes within Hackney.

This was the first time that the CHSCB QA sub-committee had attempted to audit services provided at this level and the complexity of structures and patterns of service delivery presented a number of challenges which have generated learning about processes that may need to be implemented if similar exercises are to be undertaken in the future.

The high volume of cases being processed and worked with at tier 2 made it difficult to audit a sufficient number of cases to confidently conclude that findings from these would be representative of general practice. However, although the relatively small sample of cases audited was insufficient to draw any definitive conclusions from about how well risk is being managed within preventative services, some general observations were possible and the process adopted enabled the sub-committee to gather some valuable 'practice knowledge' from Managers and practitioners across a wide range of agencies about how well local arrangements were operating to safeguard children.

Context

There were two key drivers for the current audit. These were:

1. That in January 2011, the CHSCB concluded a third Serious Case Review that had recommended that we ensure that thresholds for referral to Tier 3 are properly understood and applied by all agencies. This review also highlighted concerns about the degree to which services were coordinating to meet the needs of children at Tier 2. It should be noted however this SRC covered a period prior to January 2010.

2. There had been a significant reduction in the number of children subject to Child Protection Plans in Hackney since March 2010. Whilst much data analysis and auditing had taken place at tier 3 to interrogate this, there were two hypotheses that need to be explored in relation to the wider picture and the contribution that Tier 2 services may be making to this reduction. One of these was that the effectiveness of Tier 2 services was now having an impact, with preventative interventions reducing the need for cases to escalate to Child Protection. The other was that there could be some cases where risks were high that were being inappropriately held at tier 2, either because risks were not being identified or there was a perception that they would not meet the threshold for Tier 3.

Local Arrangements

The Hackney Child Wellbeing model was adopted by the key agencies working with children and families in the area in July 2009. This sets out the currently agreed thresholds for access to services at different levels of need. The highest level of need is Tier 3, where children are defined as being in need of 'Child Protection' services. At this level Children Social Care

should be involved and specialist child protection interventions should be provided through multi-agency arrangements led by Children's Social Care.

Tier 2 services are those that are offered to families as 'Targeted Safeguarding' responses, where there are concerns about a Child's welfare which require an integrated response from a variety of practitioners but concerns are not at a level that requires a 'child protection' response. Tier 2 is separated into two sub-levels – Tier 2A and Tier 2B, with Tier 2B referring to more complex situations where there are multiple concerns and engagement between the family and professionals at lower levels of intervention is not proving effective.

Tier 1 covers universal services and situations where a family may require some additional support or intervention from one or more agencies but any difficulties are not of a serious nature.

There are a number of systems currently in place within Hackney that serve to signpost individual children and families to the appropriate level of provision to meet their needs. Some of these are currently under review or subject to development. Key systems that were in place at the time of the Audit activity included:

- Partnership Triage arrangements, which were set up to process police Merlin reports on all incidents where children or young people were involved and are now being extended to process a wider range of information sharing requests. A number of key agencies are able to share information from their own databases to contribute to an assessment of the child's needs. The Triage manager has responsibility for deciding which the most appropriate agencies are to respond to a child's needs or receive information about them and a collated information sheet is 'handed off' to these agencies.
- Six 'Multi-Agency Team Panels' (MATs) based in each of the six school cluster areas that meet at regular intervals (monthly) to consider the needs of children aged 0-4yrs who have been identified by one or more agency as requiring additional support. The agency representatives agree on the most appropriate service provision and a lead agency for the child and family and review progress periodically. There are plans to extend the age range of children that the MATs will consider to 0-11 years in the future and for these to be chaired by qualified Social Workers employed through the Learning Trust
- The Youth Partnership Resource and Review Panel is Borough-wide and made up of representatives from a broad range of agencies working with young people within Hackney. The panel meets fortnightly to pool information and identify an appropriate lead agency for the Borough's most complex young people, aged 11-18yrs. The Panel is chaired by the Assistant Director Young Hackney
- School level Multi-Agency Panel (MAP) meetings, held termly within individual schools to consider children who need additional support within the school

There are a number of services that currently provide direct services and interventions with children that have needs as defined within tier 2 of the Child Well-being model. These include, amongst others:

- Tier 2 Social Work services provided by Children's Social Care (this provision is due to cease at the end of July 2011)
- Targeted Health Visiting services for children with additional needs
- Children's Centre based Family Support services
- Family Intervention Projects run by the Youth Offending Team (restructured into Young Hackney from July 2011)

<u>Process</u>

The proposed process for completing this audit included audits of individual cases dealt with through Tier 2 processes and services and observation of multi-agency meetings.

A sample of cases (29 in total) from a range of sources were jointly audited by a multi-agency group of professionals at a full day audit workshop. The auditing group consisted of all members of the Quality Assurance sub-committee and a number of additional managers and

practitioners from key agencies, selected for their service knowledge and safeguarding expertise.
The sample of cases audited consisted of:

- Review Panel
- 5 cases processed through MAT meetings and the Youth Partnership Resource and 9 cases dealt with through Partnership Triage
- 4 cases held by Tier 2 Social work services
- 6 cases referred to Children's Social Care First Response Team
- 3 cases receiving services from YOT based FiPs
- 1 case considered at a school-based multi-agency panel meeting
- 1 case held by Health Visiting services

The case audits were based only on a review of paperwork and did not involve any interviews with staff. Agencies were asked to provide key documents that would document the information considered and the decisions made on cases that were randomly selected by CHSCB staff. There were no opportunities within this exercise to seek additional information or clarification from individual agencies. Care has been taken in the analysis of the findings to ensure that generalised findings are not drawn from cases where information was incomplete.

The intention had been to complete a significantly higher number of audits than was accomplished. Those involved in the auditing found it important to discuss cases in some detail in order to reach agreement on judgements across the different agencies involved. The discursive nature of the exercise enabled the identification of differing views, practices and understandings across agencies and was agreed by all to have generated some very useful learning that went beyond the immediate scope of the exercise. Time was allocated to discussion of themes arising from the audits and sharing of general observations.

MAT meetings held in three different cluster areas and a meeting of the YPPRP were observed by managers from the CHSCB team and the Children's Social Care Safeguarding service.

Overall findings, observations and learning

The findings presented within this section should be treated as preliminary and it is important that those reading this report are aware that the audit sample and methodology were not sufficiently extensive and detailed to establish findings of high reliability. The findings set out below should therefore be applied tentatively and should only be seen as indicative at this stage.

The overall findings from this exercise suggest that it in the majority of cases audited, levels of risk and need were being effectively identified and responded to within tier 2 arrangements, although the auditing activity was not extensive enough to establish whether this is the case in all service areas. No significant concerns about risk management were identified in any of the cases audited. In a very small number of cases observations were made about potential risks not being fully recognised. These mostly related to domestic violence cases and there was some evidence that workers felt unsure about how concerned they should be about incidents of domestic violence.

The threshold criteria as set out in the Hackney Child Well-being Model seemed to be well understood and applied within multi-agency arrangements, although this was less true for some individual agencies that are not part of the Triage or Panel arrangements. However it was notable that there were gaps in the understanding and application of the Barnardo's Risk Assessment tool relating to domestic violence. This did not appear to be widely applied and understood as part of the Hackney Child Well-being Model. It was also observed that the Child Well-being model does not currently reflect the necessity of differential application for children at different stages of development, which at times seemed to generate some differences in professional interpretation of the thresholds. It was suggested that developing the model further to incorporate reference to child development would be helpful, in particular to help professionals apply the model more confidently to adolescents.

Multi-agency consideration and information-sharing, both through the Triage service and Multi-Agency Team panel meetings, appeared to be helpful in facilitating accurate and timely identification of safeguarding concerns. Both of these systems seemed to benefit from access to the safeguarding expertise of social workers. These forums also appeared to be effective in monitoring and reviewing potential safeguarding concerns and ensuring that concerns were escalated to tier 3 Children's Social Care where necessary. The Multi-agency Team panels were observed to promote good inter-agency relationships and understanding of available services. The absence of defined links with adult service, particularly adult mental health services, was identified as a significant gap within these arrangements. It was noted that there is no formal input from adult mental health service into the Triage systems and that case discussions and planning at Multi-Agency Team panel meetings where there were parental mental health issues were compromised by the absence of input from adult services.

The audits and data suggest that there continues to be a high number of inappropriate referrals to Children's Social Care. This was particularly true for cases that were referred by a single agency and had not been considered in a multi-agency forum. The standard of some referrals was poor with referrers failing to articulate what risks they thought were present and what level of response they expected.

The quality of information-sharing between agencies when responsibility was passing from one service to another was generally good. However, on some cases it was felt that tier 2 services did not always have full information about the history of past concerns and agency involvement on a case, particularly where there had been previous involvement with Children's Social Care. It was noted that recording formats in some agencies would benefit from review to make them more understandable and accessible, particularly where these are also used to provide referral information to other agencies.

There was some evidence of delay in services making referrals to Tier 3 Children's Social Care, particularly where the case had previously been held at tier 3 and subsequently closed or where previous referrals had not been accepted. There were no cases in which delays were felt to have left a child at risk of significant harm. There were a few cases in which there was evidence of un-resolved differences of judgement between Tier 2 and Tier 3 services. In some cases professionals seemed to be more confident in pursuing a referral to tier 3 following discussion with colleagues at multi-agency meetings, but this led to delays in progressing these. These observations were perceived by participants in the audit workshop as reflecting more general issues within the inter-agency relationships and to reinforce the need to support professionals to act assertively, be clear about their concerns and to find ways of resolving either real or perceived, differences of opinion. It was also felt that professionals needed to be clear and confident in situations where Children's Social Care had not accepted a previous referral, about pursuing a further referral if new concerns emerged in the course of their work with a family.

Participants in the workshop felt that there was a need for professionals in all agencies to receive information and training about the Common Support Framework to ensure that families are signposted to appropriate services and to reduce the number of inappropriate referrals to Children's Social Care. It was felt that a limited number of professionals are aware of the agreed processes and thresholds and that information needs to be shared more widely, particularly with GPs, some hospital-based services, schools and voluntary organisations.

Key findings in relation to specific processes and services

In this section more detailed findings relating to individual services and multi-agency processes are presented

MAT meetings and YPRRP

A total of 5 cases considered through these Tier 2 multi-agency planning meetings were audited. Finding from these audits were that:

- In all cases the referral to a Multi-agency panel meeting was felt to be appropriate
- In all cases risk factors were appropriately identified and assessed
- In all cases the threshold criteria set out in the Hackney Child Wellbeing Model were felt to have been accurately applied.
- In all cases the actions taken and plans put in place were judged to be appropriate and proportionate to the level of need identified
- All cases were judged to be held at the appropriate tier of service
- There was evidence of appropriate consultation with tier 3 services in relation to possible child protection issues where this was necessary with the advice given being integrated into case planning
- The process of sharing information and jointly considering risk indicators was felt to have facilitated informed decision-making about levels of risk. One case was appropriately referred on to Tier 3 following identification of risk factors by the panel. In another case, when new information came to light at a review stage, a decision was appropriately made to refer to Tier 3

Additional observations from the audits about MAT and YPRRP meetings included that:

- Monitoring the progress of interventions over time was helpful to judge whether anticipated outcomes were being achieved
- Multi-agency discussions on complex cases where there was a lengthy history of professional involvement contributed to identification of repeating trends and risks
- Where no services had previously been offered the panel meetings provided a good forum for formulating a support plan with the most appropriate services being offered rather than a single agency offering a service that may not best meet the family's needs
- Concerns were raised about the absence of adult mental health services from discussions where their were issues relating to parental mental health
- Panel meetings provide a useful forum for reassessing potential safeguarding issues on a regular basis, through reviews and updates

Additional observations from managers that observed panel meetings included that:

- The contribution of multiple perspectives from the various agencies was seemed to be extremely useful and to enhance both the assessment and analysis of need and decision-making about service provision
- Regular panel meetings appeared to have promoted strong inter-agency relationships and a good understanding between the various agencies represented of the roles of different professional and of the services available in local area
- Reviewing mechanisms for cases that had been considered at panel meetings previously were helpful in checking on progress and adapting plans where appropriate
- Tier 2 Social Workers attending panel meetings were able to contribute safeguarding expertise which was extremely helpful in facilitating identification of child protection concerns, advising on appropriate actions and acting as an interface with tier 3 services.
- Tier 2 social workers were also able to assist other professionals to take a balanced view of risk, to identify how lower levels of risk could be managed through tier 2 services and to resist referring cases to tier 3 where they would not meet the threshold for this level of service
- There was no apparent 'link-up' between panel arrangements for older young people and the panel arrangements for younger children. Where a young person was considered at the YPRRP and there were younger children in the family there was no way of knowing whether a different group of professionals were already involved with the younger children and the family.
- In meetings where a high volume of children or young people were being considered there were some instances where there was insufficient time to hold a full discussion about all the children being presented at the Panel, with the risk that some needs and risks may not have been identified. This is likely to be an increasing challenge at the remits of the MAT meetings extend.

- There was good evidence that Panel meetings had the potential to provided a forum where wider themes in relation to practice issues and patterns of need could be identified and creative and collective responses could be generated. In the YPRRP meeting that was observed, professionals were able to connect the behaviours and vulnerabilities of a particular group of young women and agreed that a separate meeting of involved professionals be arranged to consider appropriate and coordinated responses

Triage

A total of 9 cases that were processed through Partnership Triage were audited. Finding from these audits were that:

- In all case but one case the referral to Triage was felt to be appropriate. In the one case a MAT panel had asked Triage to forward a referral to Children's Social Care. The MAT panel should have made this referral directly. However the referral was processed by Triage without entailing any delays.
- In all cases risk factors were appropriately identified and assessed.
- In all cases, the threshold criteria set out in the Hackney Child Wellbeing Model were felt to have been accurately applied.
- Actions taken were judged to be appropriate and proportionate to the level of need identified.
- All cases were judged to be handed off to the appropriate tier of service.
- In all cases safeguarding issues were appropriately identified and acted on.

Additional observations from the audits about referrals processed through triage included:

- All referrals were dealt with in a timely way through the triage process.
- In the majority of cases the information provided by the police on Merlin notifications was of a high quality. Information was comprehensive, clear and relevant.
- There was evidence of some quite significant delays in the police sending reports to triage on several cases.
- Some elements of the Triage hand-off reports were difficult to understand for people who were not used to reading these reports. It would be useful for the service to review the recording format to ensure that information is easily understood. It would be helpful to include a clearer analysis of risk factors and needs identified. It would also be helpful for receiving agencies if Hand-off reports clearly outlined the anticipated response or service from the agency that these are being sent to.

Tier 2 Social work services

A total of 4 cases held by the Tier 2 Social Work Service were audited. Finding from these audits were that:

- In most cases the referral to tier 2 was felt to be appropriate. In one case the complex risk factors were not felt to have been fully identified at tier 3 and auditors felt that the case should have remained open at tier 3 rather than referred on to tier 2. This case was subsequently referred back to tier 3 appropriately
- In most cases risk factors were appropriately identified and assessed although the risk from domestic violence were not fully recognised in the case referred to above
- In most cases the threshold criteria set out in the Hackney Child Wellbeing Model were felt to have been accurately applied.
- In all cases the actions taken and plans put in place were judged to be appropriate and proportionate to the level of need identified other than in the one case where issues relating to domestic violence were not fully addressed
- Most cases were judged to be held at the appropriate tier of service. In the one case where the complex level of risk indicated that a tier 3 service would be more suitable the appropriate referral had been made

- There was evidence of appropriate consultation with tier 3 services in relation to possible child protection issues where this was necessary
- In all cases safeguarding issues were appropriately identified and acted on, with the exception of domestic violence issues not fully addressed in one case.

Additional observations from the audits of Tier 2 social work services included:

- In all cases held by this service the needs were complex and it would have been difficult for other agencies to address these in a holistic way. Levels of risk were often significant and close to the threshold for tier 3 intervention. Careful judgements on safeguarding issues were required on these cases.

Cases referred to CSC First Response Team from Tier 2 services

A total of 6 cases that had been referred to the First Response Team in Children's Social Care were audited. Finding from these audits were that:

- In two thirds of the cases considered, the referral to Children's Social Care was not felt to be appropriate. In several cases there was no indication of safeguarding issues and some cases it was not clear why information was being shared
- In all cases any risk factors that were present were appropriately identified and assessed
- In all cases the threshold criteria set out in the Hackney Child Wellbeing Model were felt to have been accurately applied by the service.
- In all cases the actions taken were judged to be appropriate and proportionate to the level of need identified
- All cases were judged to be held at the appropriate tier of service following consideration by FRT
- In all cases safeguarding issues were appropriately identified and acted on

Additional observations in relation to FRT referrals included:

- In several cases it was felt that the referral seemed to have been made as a cautionary measure, even though there was no clear evidence of safeguarding issues. In most of these cases there was no indication from the referrer of what action they were expecting Children's Social Care to make. In a some cases a referral to tier 2 services would have been more appropriate, but in other cases there was no indication of a need for any additional support
- There was indication of a need for training in the Hackney Child Wellbeing Model for midwifery and pre-natal staff

YOT based FiPs

Three cases held by the YOT based Family Intervention Projects were audited. Finding from these audits were that:

- In all cases the referral to the FiP was felt to be appropriate
- In all cases risk factors were appropriately identified and assessed
- In all cases the threshold criteria set out in the Hackney Child Wellbeing Model were felt to have been accurately applied.
- In all cases the actions taken and plans put in place were judged to be appropriate and proportionate to the level of need identified
- All cases were judged to be held at the appropriate tier of service
- The interface with tier 3 services was appropriate on all cases. In one case work was being jointly undertaken with Children's Social Care, in another case where concerns that would meet the tier 3 threshold were identified, helpful discussions took place between service areas and agreement was reached about how that would be managed.
- In all cases safeguarding issues were appropriately identified and acted on

Additional observations from the audits of FiP services included:

- Assessments undertaken within the service were thorough and well presented. In one case it was felt that it would have been appropriate to included assessment of the young person's siblings
- There was evidence that the service was able to provide effective and intensive interventions in relatively high risk situations to address potential safeguarding issues

School-based multi-agency panel meeting

Only one case considered at a MAP meeting was audited. This did not allow for any generalise findings. However observations from this one case were that:

The case discussions at the MAP meeting focussed on the child's behaviour in school and it would have been helpful to consider wider contextual information. The case had previously been held at tier 3 so there was an assumption that there were family factors that may be impacting on behaviour. There was reference to Kids Company having been involved for a period of two years but no report from this agency was considered at the MAP meeting.

Health Visiting services

Only one case held by the Health Visiting service was audited. This did not allow for any generalise findings. However observations from this one case were that the family were being appropriately supported by the Health Visitor and that the level of involvement was proportionate to the needs and risks identified in the case.

Recommendations for future action

Whilst this audit process was initiated in response to a number of local issues raised through Serious Case Reviews and Ofsted inspections, it is noteworthy that the recent Review of Child Protection Services completed by Professor Munro recommends that the role of LSCBs is extended to cover safeguarding activities within preventative services. If this recommendation is accepted by the Government the CHSCB will need to consider the extent to which it will need to expand it's Quality Assurance activities to meet this expectation. Given the shift in thresholds for services over the past few years it would be appropriate for the CHSCB to consider undertaking more Quality Assurance activities within preventative services whether or not this becomes a formal requirement by the government.

It is therefore proposed that the Quality Assurance sub-committee should:

- Incorporate on-going audit and review of processes and services for responding to the needs of children at Tier 2 into their Quality Assurance framework to ensure that risk is effectively managed – particularly through periods where arrangements are subject to change. It is proposed that two audit events are scheduled in the coming year.
- Pursue further auditing activity of preventative services include more in-depth exploration of a small number of cases which should including discussion with practitioners and 'follow through' of cases 'handed off' by Triage or referred on to preventative services by Children's Social Care (either following NFA by FRT or case-closure by A&A/CIN)
- Make recommendations to the CSF steering group about the need to undertake extensive awareness-raising of agreed processes and thresholds within the children's workforce and relevant adult services and stress to all Board agencies the need to ensure that staff attend this training
- Recommend to the Children and Families Strategy Group a review of the Child Well-being Model to include reference to developmental stages (this may just require a general guidance note)
- Ask the Children and Families Strategy Group to consider the impact of the loss of Tier 2 Social Work services on the provision of services and access to advice and how safeguarding expertise can be made available at multi-agency meetings in the absence of this provision

- Recommend that the CYP strategic group ensures that there are structures and processes in place to ensure information-sharing between the various panels about children that they are considering to ensure a consistent approach to supporting families where there are a number of siblings of varying ages (note – this recommendation has already been responded to via the Partnership Triage Operational Group)
- Recommend that the relevant individual agencies consider reviewing recording formats to prompt clarity about concerns, risks and rationale for decisions made.
- Recommend to all agencies that they consider how they can raise awareness of the Barnardo's risk matrix for Domestic violence and support their staff in developing skills in responding to the needs of children and families where domestic violence occurs

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