

MULTI-AGENCY AUDIT OVERVIEW REPORT 2024

Audit area: Children not in receipt of full-time education

1. Introduction

A thematic multi agency audit was undertaken by BSCP following previous discussion raised at the Board in relation to the potential safeguarding risks for children outside of mainstream education.

2. Methodology

An audit tool was devised by the Bromley Safeguarding Children Partnership and circulated for completion to a range of partners including Children's Social Care, Metropolitan Police, Bromley Housing, Youth Justice, Early Intervention and Family Support, Oxleas CAMHS, Bromley Y, Bromley Healthcare, Schools and Education Welfare, GPs, the SEL Integrated Care Board/General Practitioners, the Probation service and Bromley & Croydon Women's Aid. All partners were asked to judge the quality of work in their agency against the ILACS Grade Descriptors (Outstanding, Good, Requires Improvement to be Good, Inadequate) and the definitions were provided in the audit tool.

Findings were analysed, and a subsequent learning workshop will be organised to ensure feedback and learning is identified via the BSCP's Performance, Challenge and Impact (PCI) subgroup.

3. Returns

A total of 60 completed audits were received from across 12 agencies/services.

A breakdown of submissions by agency is:

Children's Social Care – 7 (of 8)

Early Intervention & Family Support – 7

Metropolitan Police – 7

Housing – 1

Probation – 1

Bromley Y – 6

Oxleas CAMHS – 6

ICB/GPs – 8

Bromley Healthcare (Health Visiting and School Nursing) – 7

Croydon and Bromley Women's Aid - 1

School – 1

LA Education Dept/Education Welfare – 8

4. Outcomes

Similarly to the previous multi-agency audit, there were **some differences in the grading outcomes between partner agencies**. The focus and style of audits also continued to be different, with Children's Social Care audits being very detailed and long, while other agencies took a briefer more narrative and chronological based approach to analysing the quality of response. Some agencies did not have sufficient levels of involvement with the children and young people concerned to be able to provide a graded judgement, or provide historical information only as they had not been involved during the time frame scope of the audit (the six months leading up to the incidents in which the young people suffered harm). This pattern was also a continuation from the previous multi-agency audit, but the selected cohort in fact contained a number of children with whom Children's Social Care was no longer involved (5 of the 8 cases audited were closed at the time of the audit)

Partners across the local Health economy were most likely to identify gaps that led them to grade as Requires Improvement to be Good from their agency perspective, with Bromley Y grading itself as Inadequate for overall impact in relation to two of the children audited in the cohort. **Given the audit theme of children not in education, there is assurance from the fact that Education professionals identified good practice and overall impact for all the children in the cohort**, and the Metropolitan Police identified that expected Police practices and procedures were followed with respect of all the children audited, meaning they could grade as Good in relation to their agency role.

Overall grading was as follows from the returned audits:

Children's Social Care – Good 4, Requires Improvement 3

Integrated Care Board/GPs – Good 1, Requires Improvement 7

Bromley Healthcare – Good 4, Requires Improvement 1

Oxleas CAMHS – Good 4, Requires Improvement 2

Bromley Y – Good 1, Requires Improvement 2, Inadequate 2

Schools – Good 1

LA Education/Education Welfare – Good 6

Met Police – Good 7

5. Thematic Findings / Analysis

Analysis of the audit findings identified the following themes within the agencies with the most significant involvements with the cohort of children whose records were audited:

The Police identified **consistently sharing relevant information with key partner agencies, including through participation in strategy meetings and attending promptly with missing episodes in timely ways**. Where beneficial, **expertise of social workers has been sought and advice acted upon** and the Police have been aware of risk factors present for some children who are not in education as well as whether children have a CIN or CP plan. **Procedures are being implemented well** to support the work of key statutory partners, particularly Children's Social Care.

Oxleas CAMHS identified a range of good practice examples across the audited cohort. The strongest practice was characterised **by persistence in seeking to engage with young people and families**, as well as following up and sharing information with partner agencies. This includes good examples of **joined up safety planning** and supporting school reintegration for a young person. In some cases **practice would have been strengthened by greater cohesion between CAMHS and GPs, particularly in relation to referrals**. Audits also identified a **small number of CAMHS involvements where communication with parents could have been improved**.

GP audits raised the impact on child vulnerability of the **length of time children and young people are waiting for Autism Spectrum Disorder (ASD) assessment**. On a small number of cases there were some communication/information sharing concerns including from CAMHS and responding to requests for safeguarding information. However, the GP audits raised questions that relate centrally to partners expectations of GPs in relation to home schooling and how to access support whilst awaiting for example an ASD assessment. These questions relate to whether there should be a prompt on an ASD assessment form to also refer to EIFS or parenting classes so there is a support offer in the interim, whether GPs should refer all school refusers to EIFS, whether GPs should refer to Education Welfare if a parent tells them they are home educating, and whether a GP registration question of school age children should include where a child attends school.

Bromley Healthcare identified some persistent practice to make numerous attempts to update a young person's health needs assessment, and some examples of strong liaison between health visitors and GPs. **Sometimes plans for the EHE school nursing service are unclear and this may be an area of practice that can be strengthened**.

Bromley Y identified in a number of cases that practice can be strengthened where families signposted to receive earlier support, particularly via the MHST. Strengthened engagements with all agencies and families was considered likely to help achieve preventive work with families and identifying the best pathways for young people at an earlier stage. Connecting with the GP audits, **Bromley Y identify that more joined up training with GPs may be helpful to support the identification of appropriate referrals to Bromley Y at an early stage of need** developing for young people. There is a clear sense across health services that the introduction of the iSPA will both help with achieving earlier signposting of young people to the right support and will improve communications and information sharing. Health partners may wish to therefore focus on the positive impact of the iSPA in the next cycle of multi-agency audits.

Good practice was identified in Bromley Y in relation to some examples of safety planning and risk assessment being regularly reviewed and shared with parents and schools. On one case this supported CAMHS accepting a referral in a timely way.

Education audits provide a picture of strong assurance. This includes EHE reviews happening in timescale and a family being supported when it was quickly identified by Education Officers that a family appeared to be being pushed involuntarily to EHE with their child. Schools link well with the Inclusion Service and there is timely identification of the most appropriate PRU provision and of specialist support needed by young people in the audited cohort. Adaptations to school timetables work well for young people and this is identified across more than one agency. There is evidence of the LA's Education Safeguarding Officer (ESO) being engaged positively where professional curiosity indicated that there may be factors around EHE and school provision that were affecting a child's welfare. Practice can be strengthened in terms of schools referring consistently to the LA's Gateway Panel for support and also that a CAF process for one child may have achieved earlier access to education via the Personalised Education team. **The theme of signposting of children for earlier support is evident across partners.**

Children's Social Care findings were impacted by a number of cases being closed at the point of audit. **The quality of assessment was a strength and of social work visits.** Good multi agency work on one case saw stability achieved for a young person and a team around the child agreed. There was strong link up with the LA's Education service, for instance where the EHE team could not get to see a child and the case escalated appropriately to a CP plan and pre-proceedings work which achieved desired outcomes and the case was closed. Step downs to EIFS were achieved on the basis of good quality assessment with clear and concise analysis. Where some practice could be strengthened, there was a sense that the pace of work could have been quicker and more support given around education at an earlier stage. Further, for one young person, escalation to a CP plan could have happened sooner.

Early Intervention and Family Support (EIFS) provide a picture that counteracts the views of other partners that earlier signposting and support, as well as potentially filling waiting times for instance for ASD assessment with other support services, will be a solution that will help to manage child vulnerabilities for this cohort of children. **Concern regarding levels of parental engagement was the most prominent theme across the EIFS audits.** Findings of the children audited were that one mother attended only one of five sessions of a parenting course, for another young

person the parent had always chosen not to access the EIFS/BCP support despite a number of referrals and attempts to engage, for another family the preference was to work on mental health issues rather than parenting, and for another young person a CAF had to be closed because the mother did not want to take part. **Where parents had engaged, outcomes were improved for children**, with one parent being successfully linked with other support pathways for families affected by ASD.

One young person audited became looked after and information was no longer held by local agencies which meant the multi-agency auditing process was unfortunately not beneficial in terms of learning.

The cohort audited is clearly a very small number of children and therefore overall themes cannot be considered statistically reliable to project to the overall cohort of children not in education. However, common themes that can be addressed that are impacting on all agencies include finding a way that families can access support and have pathways identified to address need at an early stage, the significance of child mental health and SEND as a vulnerability factor among children not in education and how to best manage and reduce those vulnerabilities where children may sometimes not be in the line of sight of agencies (CSC was used well by partners in this regard), and achieving the engagement of families with support offered (this impacted on all agencies). There were common themes where inter-agency communication could be improved and strengthened, and a review of the impact for health partners of the introduction of the iSPA will be of real benefit for all agencies working with this cohort of children.

This audit also saw similar differences as with the previous multi-agency audit between agencies around style of auditing. It is likely to be helpful to the multi-agency auditing process moving forwards if we agree some specific auditing standards through a workshop.

6. Issues for Consideration / Actions

Recommendations for the BSCP action plan arising from this multi-agency audit are:

1. Health partners review the impact of the iSPA for improved signposting and support pathways for children and young people.
2. An audit standards workshop be held to seek to deliver consistent auditing practice across agencies for the purpose of multi-agency audits.
3. Clarity of expectations for GPs in relation to this cohort of children to be agreed and written for GPs.
4. A task and finish group to explore how to strengthen engagement with families where early support is identified to be likely to improve outcomes for children who are being home educated so that child vulnerability can be reduced.

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