

Introduction

A thematic multi agency audit was undertaken in January 2023 concerning a cohort of six children who had suffered Serious Youth Violence during the summer of 2022 and for whom there were risks of extra familial harm. The audit was followed up with a cross Partnership learning event held on 25 January 2023, from which recommendations will be agreed and progressed through the Bromley Safeguarding Children Partnership (BSCP) action plan.

Methodology

An audit tool was devised by the Quality Assurance Lead Manager in Children's Social Care and circulated for completion to a wide range of partners including Children's Social Care, Metropolitan Police, Bromley Housing, Youth Justice, Early Intervention and Family Support, Oxleas CAMHS and Bromley Y, Change Grow Live (Substance Misuse), School Designated Safeguarding Leads, Bromley Healthcare, the SE Integrated Care Board/General Practitioners and the Probation service. 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 learning workshop was led by Quality Assurance leads in Children's Social Care to explore themes and trends identified in the prevention and response to extra familial harm that the small cohort of six young people indicated and consider strategically what actions the partners can take forwards to strengthen our continuous improvement in our joint work for children at risk of serious youth violence or exploitation. The learning workshop was attended by 25 colleagues representing all the agencies that took part in the multi-agency audit.

The learning workshop was held in advance of more strategic development days across the partnership and so fed in to the MEGA/MACE away day held in February 2023 and working towards a development day being planned by the Metropolitan Police to further support partners continued progress in this area.

Returns

A breakdown of submissions by agency is:

Children's Social Care – 4 (of 6)

Early Intervention & Family Support – 6

Youth Justice Service – 1

Metropolitan Police – 6

Housing – 2

Probation – 2

Change Grow Live – 2

Bromley Y – 2

Oxleas CAMHS – 4

ICB/GPs – 5 (1 YP not registered with a GP)

Bromley Healthcare (Health Visiting and School Nursing) – 6

Schools 2 (of 3)

A total of 42 completed audits were received from across 12 agencies/services.

Outcomes

There were noticeable differences in the grading outcomes between partner agencies. The focus and style was also 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 young people concerned to be able to provide a graded judgement, or provided 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).

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 and to identify gaps in multi-agency plans for young people in how developmental need was being addressed as part of risk management, prevention and reduction.

Overall grading was as follows from the returned audits:

Children's Social Care – Good 3, Inadequate 1

Youth Justice Service – Good 1

Integrated Care Board/GPs – Good 1, Requires Improvement 4

Bromley Healthcare – Good 2, Requires Improvement 4

Probation – Good 1

Schools – Good 1, Requires Improvement 1

Thematic Findings/Analysis

Analysis of the audit findings identified five broad themes in the practice across the partner agencies that has significant impact on the quality of the multi-agency response to serious youth violence that were considered further in the tabletop learning workshop. In turn, these were:

1. Information Sharing and Multi Agency Communication:

Agencies all identified aspects of information sharing on a case-by-case basis that raised the issue of how to best maximise the sharing between key professionals among the partners more reliably. There were instances where information sharing was a strength and identification of information that needed to be shared with the network around a young person was achieved in a timely way.

However, on the individual child level, the picture across the agencies was that important pieces of the 'jigsaw' of information that needed to be known at key meetings was not always made available. This has impacted on the grading judgements reached around the work with some young people by Health partners, but was cited by the majority of agencies participating in the audit. For example:

- GP not sharing a significant knife crime related incident for a young person in an updating report to a child protection conference and reporting that there had not been significant incident since the last report to the network.
- Auditors being unable to find records of meetings to be able to understand the plan being worked to for young people in some cases among health partners.
- Schools not being included in key meetings concerning young people at the earliest response planning stages, eg at morning MASH or Police meetings or generally in strategy meetings following an incident of violence. This could lead to schools feeling isolated in managing risk and challenging behaviours of young people facing exploitation or risk of harm.
- Children's Social Care identified that the range of meetings to consider risk and response at key points can be impacted by different professionals from different agencies attending, and the intelligence and information not always being routinely shared or known between different internal sections within agencies. This may particularly apply in the larger and more complex agencies, but reinforces for example the importance of inclusion of and information sharing from GPs as the central conduit within the health economy.
- Agencies identified the need to ensure all historical information is available to support risk evaluation from the earliest stage possible. One young person's case was affected by moves across boroughs and delay in accessing historical information from other boroughs.
- There is not an IT system across agencies that can 'speak' with each other. This audit has flagged potential organisational risk when changing IT systems internally in relation to the quality of data migration and potential loss of data in the crossover between systems that impacts on agencies being able to have a full historical picture of a young person at risk of extra familial harm.

2. Collecting and Analysing Information:

Agencies identified that the capacity and quality of collecting and analysing information to inform risk assessment, prevention and planning was a theme to pay further attention to as partners continue to improve in preventing and responding to extra familial harm.

Children's Social Care identified a trend where once a young person had been allocated a social worker for assessment and so the statutory social care system threshold had been crossed, there could be an over emphasis in the work undertaken on the presenting referral concern that could be most confidently addressed, for example poor school attendance.

The factors associated with the risk to all of the young people subject of the audit were low school attendance, patterns over time of exclusion from school and access to alternative school provision, witnessing of domestic abuse and other neglect factors during childhood, regular moves to different areas, challenging behaviours at home and additional developmental need such as ADHD, poor receptive language and memory that had required speech and language therapy, patterns of not always being brought to significant appointments to support developmental progress during childhood and lower level concern regarding risks of criminality at different times.

However, there was not a common language across the partners as to how best to make sense of these patterns of need over time that appear to increase risk of extra familial harm for some young people and the analysis of the historical patterns and need in families that can indicate future trajectories for prevention purposes.

Agencies reflected in the learning workshop that the analysis of Adverse Childhood Experiences (ACE) is imperative to prevention and a trauma informed approach to engaging with young people and their families, as well as the clarity around the umbrella of the early help offer in the borough and the communication of this offer/how to access support throughout the different communities within the area. There were historical patterns with the young people subject of the audit that support had been offered by the Health partners led particularly on the significance of analysing and understanding the significance of Adverse Childhood Experiences. This language has subsequently started to become embedded in the Local Authority early intervention and family support service.

In brief, ACE refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. When children are exposed to adverse and stressful experiences, it can have a long lasting impact on their ability to think, interact with others, and on their learning. It has been shown that considerable and prolonged stress in childhood has lifelong consequences for a person's health and wellbeing, with negative behaviours often being used unconsciously as protective solutions to unrecognised problems dating back to childhood.

Sharing research across the partnership is considered one way to support a common knowledge base of ACE and recognition of it for prevention of extra familial harm as well as establishing a commonality of language and understanding across the partners in analysing the backgrounds of young people to inform whether risks of exploitation may become a factor. At the current time, the audits indicated that agencies are responding in a timely and well managed way after incidents of significant harm have happened, it is the prevention aspect that will benefit from a focus across the partnership in terms of multi-agency practice.

3. Quality of Plans:

Auditors across the agencies identified some good examples of child centred plans, alongside constructive and meaningful safety planning for some young people.

However, the quality of plans overall can be strengthened. In particular, health partners identified that in connection with ACE, multi-agency plans (eg Child Protection plans) were not always adept in identifying the supports required to manage behaviours that may be associated with specific additional developmental need, eg ADHD and the impact this may have on a young person's understanding of the world around them and their behaviours. Instead, multi-agency plans focused more on risk management but could have been more specific about the actual support being provided and how that would mitigate risk.

Children's Social Care identify that the nature of a formal child protection conference is not necessarily the best forum for young people and their families who are experiencing extra familial harm to engage with targeted support to reduce exploitation risks. The learning workshop considered alternative models that may be considered across the partnership for engaging young people in their risk management planning and support, and recognised that professionals representing 'authority' may, however hard they try, not be able to be accepted by young people as adults they can trust to help them.

Other aspects the audit and learning workshop identified that may affect the quality of plans included schools not always being in attendance at strategy meetings, the statutory requirement being that Children's Social Care, Health and Police be represented at these, and the impact this has on information sharing and planning. Further, resource factors affecting some agencies also had an impact (see Resource section below).

Planning was also for some young people affected by agencies referring for services that young people did not consider would be necessary or helpful for them. This can then risk feeding in to the perception of young people not engaging with help and support offered as well as use valuable resource of some partners offering sessions that young people are sometimes not brought to or cancel themselves. This was relevant in one audited case where substance misuse services invested considerable time and effort to seek to meet with a young person referred by a partner, who did not see value or wish to meet and there was limited evidence that substance use was a primary factor in the extra familial harm risks that were present for that particular young person. Before the referral was made, the young person had said that he did not wish to attend or feel that he needed to.

4. Resource:

Agencies identified in their audits the impact of resource limitations affecting their prevention and response to extra familial harm. For example, health visitors and school nurses attend initial child protection conferences but the resource is presently unable to extend to being able to always attend reviews. This can impact on the contribution of those professionals to the planning and contributing from their agency perspective to risk reduction. This can in turn impact the quality of plans where specific actions that such professionals may be able to assist with to reduce risk are harder to identify in the multi-agency plan, and may reduce the impact of ACE being fully analysed and considered.

Agencies identified that young people received a different intervention depending on the Emergency Department (ED) they presented at and the borough they reside in. Red Thread at Denmark Hill intervenes at a key 'teachable' moment when young people present at the hospital with injuries. For our Bromley young people that attend Denmark Hill, they will be offered and supported by Redthread only whilst they are in ED or an inpatient. Redthread is unable to offer support to Bromley residents once discharged, which limits the effectiveness of the service they offer.

Kings have tried to approach another provider for a similar support at the PRUH site but have not received a response.

Resource considerations also affect all agencies in regards staff turnover and recruitment and retention.

Agencies reflected in their audits and at the learning workshop that the increase in complexity of need and numbers of young people requiring support from younger ages around their wellbeing is something that requires careful allocation of resource available across the partners.

5. Using family networks effectively

Agencies identified that there were patterns of working hard and with persistence to engage with families in the audited cohort that was not always successful in achieving engagement, either historically or during the period in scope for the audit.

Agencies identified for some young people that consideration of the support the family network could offer was a strength and was considered in safety planning and contingency planning. But overall, the trend was the prioritisation of engaging the family networks to mitigate risk can be enhanced across partners, with all involved agencies with young people striving to focus on

exploring this with young people and parents/carers when they are in contact. In terms of prevention, these explorations can happen from the earliest stage possible.

Identifying with young people a trusted adult and being able to make more creative use of mentors as lead workers alongside the professional network are ways partners considered may support being able to follow through and move beyond mistrust of professionals who may represent formal authority to a young person and his or her family.

A targeted learning event across the partnership around disproportionality and the impact of extra familial harm in relation to culture and identity, including trajectories for black and global majority children, will be of benefit across agencies. The returned audits had gaps in relation to the role that culture and identity, and how growing up in Bromley may be experienced by young people from diverse communities in the local Bromley demographic context.

Recommendations

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

1. An Early Help Governance Board be established and consider a directory of early help services and how these will be communicated across the community.
2. Agencies to focus on Prevention as well as response and establish a common language and practice around Adverse Childhood Experiences in the context of understanding extra familial harm risks to young people and that these are then clearly identified in plans to support young people.
3. The BSCP can consider a learning and development event in the Bromley context to promote how all agencies are challenging disproportionality and trajectory planning for young people at risk of extra familial harm from diverse communities with a view to embedding creative methods of engagement.
4. Agencies need to strengthen the role of schools in the prevention and response to serious youth violence and extra familial harm so that they can consider a broader range of options to how best to support young people to prevent exclusion or alternative provision for young people at risk of extra familial harm. This includes attendance where relevant at 'morning meetings' and standard invitations to attend strategy meetings alongside the three statutory partners.
5. Agencies should work together to provide three different models for how to most effectively engage young people and their families in the best quality plans for the Partnership Board and Executive Board to review the best model of managing and reducing risk for the cohort of young people affected by extra familial harm.

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