ENHANCING MULTI-AGENCY WORKING

Learning from
BSCB MULTI-AGENCY NEGLECT AUDIT 2017

Based on 10 cases which did not meet the threshold for Children's Social Care intervention

WHAT WE WILL ACHIEVE TODAY

- Overview of the themes from Neglect audit
- Inter- agency Group work , feedback & discussion on key themes
- Partner agency Plans around Neglect

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NEGLECT DEFINITION

Working Together to Safeguard Children (2015)

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur

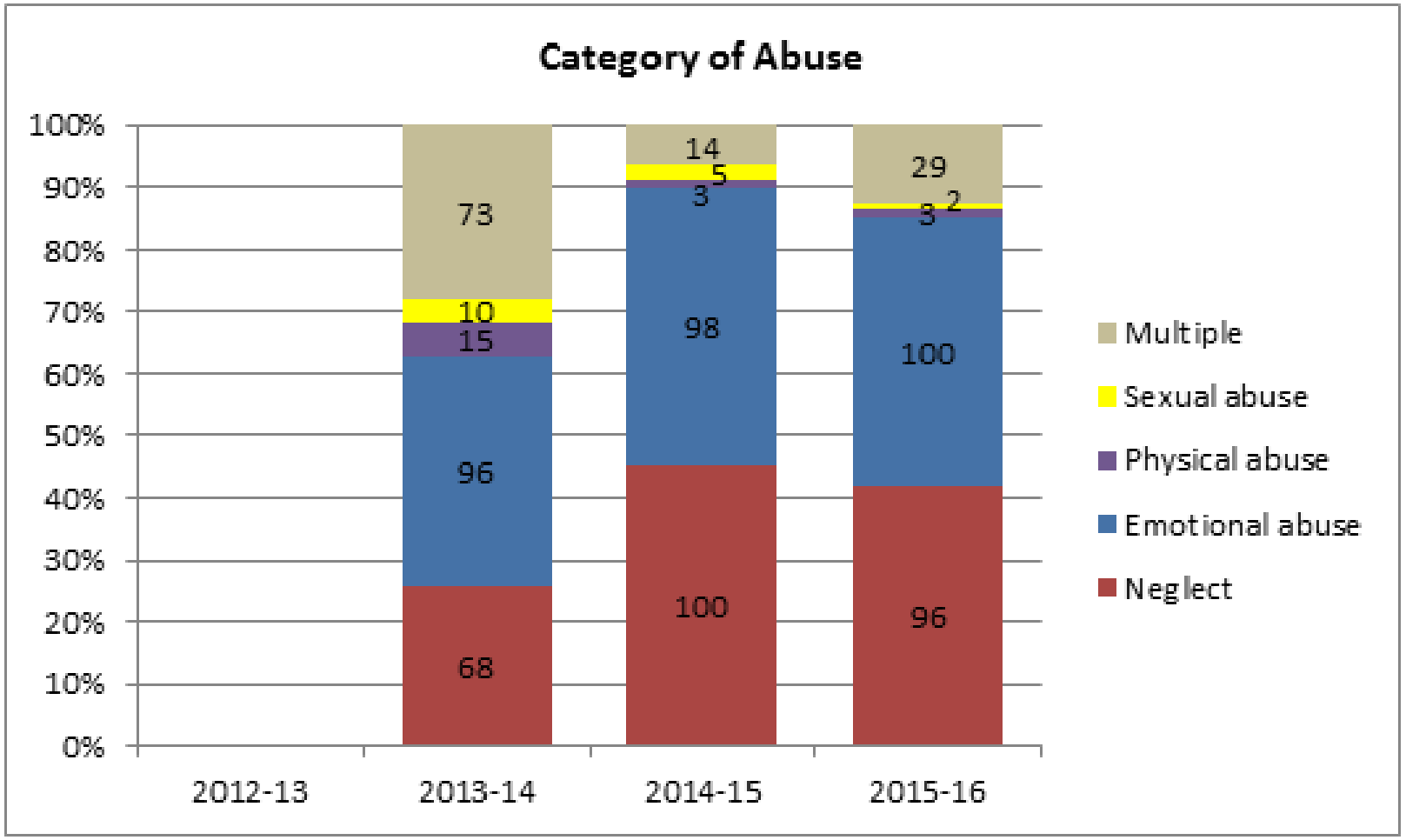
during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

NEGLECT IN BROMLEY

Initial Conference / Children Subject to a Child Protection Plan



BSCB MULTI AGENCY NEGLECT AUDIT 2017

The audit explored how the following agencies work together to identify children who are neglected, intervene to reduce risk and monitor effectively the impact of interventions

Health Visitors and School Nurses
General Practitioners (GPs)
CAMHS
The Princess Royal University Hospital
Bromley Drugs and Alcohol Service (BDAS)
Schools
Education Welfare Service (EWS)
Bromley Children's Project (BCP)
CAF Early Help
Children's Social Care (CSC)
Police
Youth Offending Service (YOS)
Housing

KEY FINDINGS - STRENGTHS

- Supportive relationships with parents (emotional & practical support)
- Effective challenge to parents
- Identifying and supporting difficulties families are facing e.g. health, housing, employment.
- Committed and skilled partnership work demonstrated eg school systems/ nurseries/ GP & H/V.
- Appropriate referrals to community agencies
- Direct work with children included examples of skilled and thoughtful work around children with disabilities.

KEY FINDINGS - CHALLENGES

- Assessing parental capacity & capacity for change eg substance misuse, M/H
- Capturing the voice of the child
- Diversity
- Direct work with children for neglect related issues eg exposure to domestic abuse, parental mental health & substance misuse.
- The individual needs of children within large families ie assessment & plans for each child
- Critical thinking around the parent'(s) narrative to remain child centred
- Effective thresholds, ie for CAF, MASH, CHIN & CP
- Reflective Supervision/ Management guidance
- Outcome focused plans (with next steps if outcomes are not met.)

THE GAPS IN MULTI-AGENCY COMMUNICATION

- Absence of connectivity with key agencies eg GP's/ BDAS
- Current & relevant information sharing to & from MASH
- Context of safeguarding concerns absent hindering agencies providing proportionate response.
- Intra agency deficits in transfers of information eg health economy, CSC, education system
- Drift & Delay in some CAF's eg key developments not being communicated.
- Effective management of meetings resulting in outcome focused plans (chair steering the issues, challenging disruptions, divergences from family/ professionals)
- Identification of risks eg disguised compliance/hidden harm

NEGLECT -THE BROMLEY PICTURE

- Missed opportunities around early identification & intervention to help identify potential risks.
- Proportionate and relevant information sharing was lacking through layers of networks
- Variable usage of key processes to assist with identification of neglect eg chronology, neglect assessment tools & interagency communication
- A lack of professional curiosity around some types of neglect where children's needs are obscured eg chronic neglect / intermittent neglect/ neglect of teenagers/ related to substance misuse & domestic abuse
- Voice of the child obscured by parent's narratives (absence of obtaining voice of the child via partner agencies or critical analysis around the parent's narrative of the child)
- Limited Reflective supervision providing support, guidance & a focus on outcomes
- Cases had reached threshold for CSC (but were not progressed within CSC) where there were existing CAF plans or where there had been repeat referrals.
- No escalation of cases by partner agencies where concerns remained about a child - challenge & escalation are an essential aspect of determining thresholds.

MULTI AGENCY PLANS

- Escalation Policy – BSCB will be ensuring all agencies are aware of this policy.
- Risk assessment tool – BSCB will be exploring multi agency Neglect risk assessment tools
- Multi – agency auditing – BSCB will be considering providing training to all agencies to promote a shared understanding of best practice
- Chronologies – use of chronologies across agencies
- **A reminder! - BSCB website** for key forms, procedures, signposting to expert services and advice. Link to London CP Procedures

CAF MULTI AGENCY LEARNING

- **Positives**
- TAC meetings responded to risks and reduced concern through multi-agency working
- Support from CAF Team to chair the more complex TACs
- SW chairing the 1st TAC has provided rigour on step downs

- **Improvements required**
- Voice of child not always heard within CAF process
- Action plans need to be SMART with clear objectives
- Response to update requests on CAFs can be poor
- CAF Closure Form needs to be utilised to provide reflections around progress made against each area of concern

GROUP WORK, INTER-AGENCY DISCUSSION & FEEDBACK

- 1/ What are the barriers around constructive inter agency communication in your agency?
- 2/ How do you incorporate the Voice of the child ?
- 3/ What are the barriers to you escalating a concern when you remain concerned about a child?

WHAT ARE THE BARRIERS AROUND CONSTRUCTIVE INTER AGENCY COMMUNICATION IN YOUR AGENCY?

GROUPWORK WITHIN THE PRESENTATION IDENTIFIED THE FOLLOWING:

- Consent from parents limiting or preventing information sharing
- Information sharing, confidentiality & data protection – knowing what you are allowed to share
- Lack of feedback MASH feedback when referral has been made/ information request from MASH
- Delays with agencies feeding back information eg to MASH
- Agencies meeting timescales eg unrealistic expectations for reports
- Frequent staff turnover - knowing the point of contact & contact details
- Lack of planning – short notice to attend meetings eg Core Group meetings /cancelled meetings
- Thresholds for neglect differing across agencies
- Identifying and naming the concern as ' neglect'
- Competencies, knowledge basis around identifying neglect
- Not taking the concerns seriously as unaware of related risks
- Under resourcing & lack of professional capacity eg school nurses
- Lack of respect for professional expertise (eg nursery's concerns around a particular child)
- Finding out the network involved with the family
- Being left out of the network eg Third Sector – Young Carers
- Borough boundaries eg school, health impede cross borough communication
- Not getting all the key agencies ' round the table'
- Lack of clarity over the issues
- Lack of knowledge of what other services are available to meet the particular need/ issue Lack of understanding of roles and responsibilities across agencies
- Lack of clarity around the outcome focus of work
- The process of understanding thresholds
- Families working well with some agencies & issues being identified by other agencies - network splitting
- Lack of consensus across agencies around interpretations of needs
- Challenging professionals within the network eg statutory and non statutory
- IT issues – eg secure emails

HOW DO YOU INCORPORATE THE VOICE OF THE CHILD?

GROUPWORK WITHIN THE PRESENTATION IDENTIFIED THE FOLLOWING:

- Asking children directly and active listening on a 1 to 1 basis
- Building good relationships with the child to help them feel safe
- Get to know the child's lived experience
- Professional curiosity and interest around the child's views
- Signs of Safety model
- Age appropriate communication/ direct work skills eg asking open questions
- Responding to the particular communication needs of children eg disabled children
- Being pro-active around taking every opportunity to talk directly with a child
- Detailed observations eg babies, play & interactions
- Directly quoting what children say
- Asking children around their views and needs on key areas
- Children being at the centre of the meetings
- Children being involved in the process
- Writing on the action plan
- Child's views informing focused planning
- Collating different evidence sources (agencies with no direct contact with the child)
- Adult facing agencies – from third parties & or parents/ extended family
- Liaising with other professionals eg pastoral staff/ attending external meetings
- Assessments of adults need to consider children
- Training around developmental stages of children & direct work tools
- BCP supervision including the voice of the child not just the parents' views
- Planning interventions eg counselling services
- Group work eg Social Skills groups – including children who don't want a 1 to 1 service
- Sickle Cell Nurse – home visit and direct work eg craft work as child may not want to engage in office/ medical setting
- Children attending CAF meetings
- Worry Boxes.

WHAT ARE THE BARRIERS TO YOU ESCALATING A CONCERN WHEN YOU REMAIN CONCERNED ABOUT A CHILD?

GROUPWORK WITHIN THE PRESENTATION IDENTIFIED THE FOLLOWING:

- Who to escalate across agencies?
- Lack of understanding of roles and responsibilities between agencies
- Lack of confidence/ experience/ familiarity leading to avoidance
- Lack of knowledge of the procedure eg professionals may think they have escalated when they had just made a phone call
- Time constraints eg gathering the evidence
- Difficulties around identification of risks eg not naming 'neglect'
- A lack of knowledge & understanding around thresholds/ thresholds not being met
- Hierarchy & power – Senior management/ professionals within agencies overriding the concerns of less senior staff
- Fear around challenging senior management within agencies
- Lack of effectiveness of escalation policy eg phone calls/ emails not being responded to (both practitioners and manager levels0
- Loss of confidence in CSC & escalation policy .

MASH

- Better quality of referrals providing key information and **consent**
- MASH Health representative to procedurally obtain info from GP especially if only limited information is available on accessible recording systems such as RIO/EMIS/National spine
- Voice of child **-** Greater consideration of non/disguised compliance and analysing potential for change in parents.
- Greater consideration of non/disguised compliance and analysing potential for change in parents.
- MASH Risk assessment template for CSC to include specific section “Voice of the child” under each column of signs of safety
- Management oversight- All referrals being screened by MASH Team manager

MASH PLAN

- MASH risk assessment template specific to each agency to ensure that relevant information
- MASH Health representative to procedurally obtain info from GP
- MASH to review process and quality of responses to referrers
- MASH Risk assessment template for CSC to include specific section “Voice of the child” under each column of signs of safety
- Any ad hoc supervision/case discussion during MASH process to be reflected on GUARDIAN

HEALTH VISITORS

- All MASH referrals will be recorded on the EMIS records, if an action is required the MASH health worker will make this clear. The practitioner will then document their own robust action plan

- The health visitor will consider writing a chronology for any complex cases and cases of neglect prior to the family transitioning into the school health service

- All cases where neglect is an ongoing issue should be discussed within supervision and have a robust action plan embedded within the supervision document

- Cases of concern or cases of identified drift will be taken to the Vulnerability panel

- Cases of concern should be discussed with the safeguarding children team and where appropriate escalated

GP's

- GPs were providing medical care for the families and there was evidence in some cases of good liaison with Health Visitors.

- GPs to code family records (to assist with identification of neglect & safeguarding issues)

- GPs to include parenting status in referrals to Improving Access to Psychological Therapies (IAPT) and to specifically record they have considered the effect on parental capacity during consultations for adult mental health problems - *To be included in the training for all GPs in January 2018 and for Practice Leads in June-December 2017*

- GPs to be informed of safeguarding concerns so that relevant parental history can be shared -*Discussions with MASH and R&A are on going to address this issue*.

BDAS CHALLENGES: LIMITED ACCESS TO THE CHILD

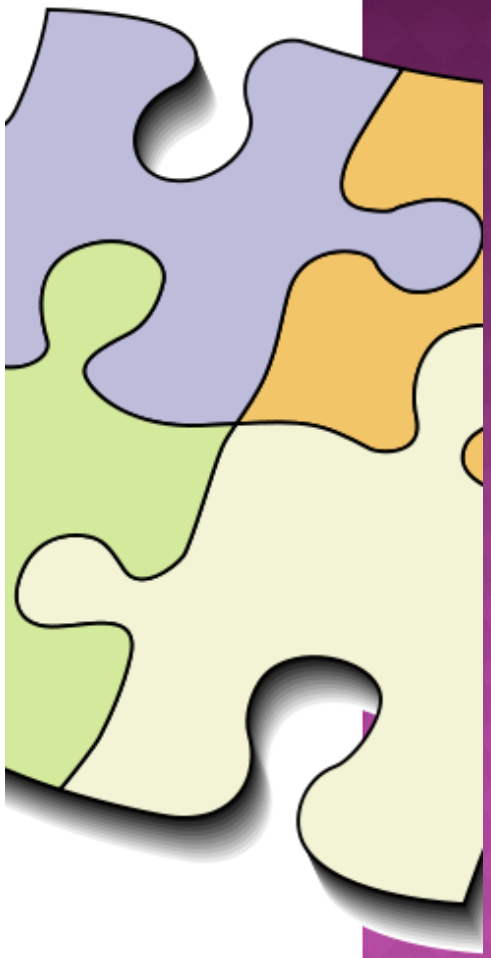
- As we are an 'adult facing' service we do not have children on the premises. This is due to limitations under Health and Safety and insurance policies.
- **Home visits:** Our main opportunity to meet with or engage with any children of our service users. These are conducted by staff who have completed 'Over the Threshold' training and who would be making observations and assessments of neglect of the child and the parent(s) capacity as well as assessing the home environment.
- The child/children are not always present. Although cgl are committed to Safeguarding and have a clear Home Visits policy we do not have the power to insist that children are present when these home visits take place. Also even when visits have been arranged, it is not uncommon for the service user to be fail to be home when our worker calls. Again we do not have a 'mandatory' power to insist that the service user complies with arrangement.

CHALLENGES: WHAT IS NEGLECT? WHAT DOES IT LOOK LIKE?

- **The voice unspoken:** We often need to translate the visual and environmental clues as the 'Voice of the Child', both with the child present or not. Sometimes we need to hear the story behind what the is being said.
- **Understanding and recognising 'Neglect'** - Some of our cohort may not always have the capacity to recognise neglect. This can be due to the effect of substance misuse, such as their state of lucidity, depression, their thoughts and perceptions. This can also be result as of their own childhood experiences in which poor parenting and neglect were the 'norm'. Some people consider neglect to require an 'active', physical form of abuse.
- **Developing and promoting professional curiosity & confidence:** The cgl worker's primary expertise is in the treatment of adult substance misuse. One of the challenges has been to instil confidence in asking awkward questions and referring cases on.
- We do not always have enough of the picture

CHALLENGES: GETTING THE WHOLE PICTURE

- **Shared and sharing information – we can only hear, what we hear.** we rely heavily on the honesty of the service user, the quality of information provided to us by referrers and information we receive through any Child Service contact such the responses to referrals we have made, meetings (TAC, CHIN. Core Group etc)
- **Consent & Confidentiality** – Workers across services not always having a good understanding of who can say what and to whom and why.
  - If and when 'informed consent' is needed.
- **Making the pieces fit:** The more information we all have, the greater our understanding of the picture. This needs to be informed by details which are current and historical, concerns or incidents and of linked: Relations/relationships – Addresses – other support – patterns of behaviour.



EDUCATION

- Schools have a good understanding in relation to the communication needs of their children and they support the children's needs through skilfully communicating with children. For example one particular school used Makaton and another school had a good understanding of a child's emotional well-being, cognition and information processing skills. This lead to one child being able to share information about what was happening at home and supported another child to engage within a S47 investigation and to understand the S47 process.
- Effective working relationships with family members ensured that concerns were identified and acted upon an early stage.
- Evidence of partnership working between agencies leading to better outcomes for children.
- Good case recording noted, Chronologies kept up to date and these chronologies captured detailed events which informed decision making.
- Safeguarding procedures followed appropriately.
- Effective planning in relation to supporting the needs of children and their families within and outside of schools.
- Partnership working and sharing information ensured that when a child moved to another school the new school were fully aware of the child's needs and family circumstances.

EDUCATION

Schools need to have a better understanding in relation to escalating concerns with Children's Social Care.

Limited information in relation to siblings. Better understanding in relation to sibling groups may inform the decision making process, identify risks and or ensure that appropriate support is provided to children and families.

Social care need to ensure that schools are kept up to date with plans for children.

YOS

- **Response and Recognition**
- **External Partnership Working = Inadequate**
- **Actions taken:**

- Management Team have been reviewing existing YOS Protocols and SLA's with external partnerships to ensure that they are fit for purpose and improve joint working arrangements.
- YOS partnership working with CAF Team identified specifically as an area requiring improvement – CAF have been invited to YOS Team Meeting in order to improve YOS/CAF working arrangements.

- **Voice of the Child**
- **Actions Taken:**

- Adopted new Assessment Tool (AssetPlus) which encourages Case Managers to seekout the Voice of the Child i.e. Self Assessment questionnaire for young person, also involvement of child in planning child focussed intervention.

YOS

- **Case Recording / Record Keeping**
- Improvement in the manner in which we record information – creation of a template for recording of information relating to interventions shared across the team – clear focus on Outcomes whether there have been met and the impact of this on the family.
- **Assessment, Analysis and Planning**
- **Action Taken:**
- YOS changing its approach to intervention from working with young people in silo to a Whole Family approach, staff team will be trained to support them in this change of approach – will lead to working with the whole family and other professionals involved with the family in a more collaborative approach.
- **Supervision and Management**
- **Action Taken:**
- Introducing a new YOS Supervision Policy based upon Signs of Safety Model

BROMLEY CLINICAL COMMISSIONING GROUP

- Ensures all health providers implement recommendations from the audit in a timely manner;
- Seek evidence from health partners for embedding and sustaining learning from the audit; and
- Ensures messages of learning and improvement are disseminated across the health economy.