Leicester LSCB Multi-agency Audit: Early Help Audit 2017

Summary

This summary (briefing) is aimed at managers and practitioner working with children and families in Leicester. Information about Domestic Violence/Abuse and Key findings/recommendations from the audit is presented. Please share this summary (briefing) with colleagues.

Background

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- A multi-agency LSCB audit on Early Help was conducted in between February and March 2017, to check compliance and seek assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to cases where a need for early help was identified; identify learning to improve practice in safeguarding children and young people earlier.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

- Clinical Commissioning Group (CCG)
- Leicestershire Police
- Children Social Care, Safeguarding Unit, Leicester City Council
- Leicestershire Partnership Trust (LPT)
- University Hospitals of Leicester (UHL)
- LSCB office

The audit included accuracy of case details, referrals and response and identification of early help and underpinning this was the 'Voice of the Child' and compliance to procedures.

Ten cases were selected for auditing by the LSCB office from a list of cases provided by Children Social Care (in two cases, the lead practitioner was from external agencies). The audit was completed by 6th March 2017.

The audit was completed by: Leicester City Council's – Safeguarding Unit, Leicestershire Police, Leicestershire Partnership Trust (LPT), and University Hospitals of Leicester (UHL). Two cases out of the 10 audited by Leicestershire Police were within scope. In relation to UHL there was brief attendance to the hospital in two cases (the rest were not known) and no safeguarding concerns or need for early help intervention identified.

What is Early Help?

According to Working Together (2015):

Early help means providing support as soon as a problem emerges, at any point in the child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising, for example, if it is provided as part of a support plan where a child has returned home to their family from care.

Effective early help relies upon local agencies working together to:

- Identify children and families who would benefit from early help
- Undertaken an assessment of the need for early help; and
- Provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.

According to the LLR LSCB Thresholds for Access to Services for Children & Families in LLR:

Early Help is the phrase used to describe services provided for children, young people and families with a very broad spectrum of needs, i.e. from emerging difficulties through to families who may be on the cusp of statutory or specialist services. Early Help services are provided by a range of organisations and teams and include single service responses through to multi-agency approaches. Agencies involved in delivering Early Help include health, education, local authorities, and voluntary and community sector. For families with multiple issues and complex needs, Early Help will include an assessment of need and a multi-agency Team around the Family process to support a coordinated response, with a lead practitioner identified. Early Help services may work alongside universal and specialist services to ensure individuals and families receive the best response to the identified needs

Good Practice (identified in one case)

- Use of both the targeted (shorter) piece of work (TAR) and Early Help Assessment (EHA) assessment were holistic and included the child's voice, mother's perspective and information obtained from key agencies.
- A timeline was produced which provided a good understanding of significant developments within key stages of the child's life.
- Evidence of professional curiosity and healthy scepticism was evident to different degrees when exploring some of the issues impacting on children and families. There was evidence that this was developed to ensure a more robust assessment, plan and intervention.
- A detailed SMART plan was devised which addressed all the areas of needs and risks.
- Timely reviews
- The management oversight/supervision was regular, developed a picture of the child's circumstances, with previous actions reviewed providing a space to reflect. Records were detailed - considered what difference the intervention was making for the child in terms of outcomes.

Key Findings

- In some cases the children had complex health needs, behavioural issues or disability/autism. The complexity in the family situation, in some cases, was compounded by parental (mother) substance and alcohol misuse, domestic violence and/or mental health issues, impacting on their ability to care for and safeguard their children. These cases should have been managed within Children Social Care (CSC) as the definition of significant harm could have been met. Despite practitioners within the early help service working hard the intended outcome was not being met and making a difference. Four cases were escalated to Children Social Care for further scrutiny by the audit group.
- There was evidence of application and compliance to procedures in some cases but not all.
- Demographic information was fully recorded in some cases but not in all and across the partnership.
- Previous history and involvement was considered in some cases but not all. In CSC information held in different systems were not sufficiently accessed to understand the child/family history and involvement. Insufficient information captured/recorded originally impacted on the service provided by early help practitioners as this information informs the service required.
- Overall there was an understanding and application of the thresholds when referring to CSC. However, in one case, there was disagreement between teams within CSC of which team/service's threshold was met – resulting in a delay in providing a service.
- Escalation of concerns took place, but there was an issue around feedback where the action that CSC said that they would carry out did not happen – whilst the person who escalated the concern believed that it had. In some case practitioners awaited the Multi-agency Agency Support Panel for a decision to step up a case rather than stepping up sooner resulting in a delay.
- Good practice was identified by LPT in communicating with very young children and using an interpreter where required. However, obtaining and considering the voice of the child was not consistent across the partnership. The Police did not speak to the children because they were not at home at the time of the police visits. Had the children's views been obtained it would have given a view on the situation from the children's perspectives and verify the adult's account. Poor practice was identified in one case where CSC had used a child as an interpreter.
- Fathers were not spoken to/involved all the cases.
- There were good example of multi-agency working but improvement is still required in inviting key partners from health (school nurses). LPT will now receive invites to all multi-agency meetings via secure e-mail meaning that LPT practitioners will not be missed.
- There was poor attendance from adult services but it is unclear whether this was due to a lack of liaison with adult services. However, the Police had contacted adult services in the two cases that they audited.
- Assessments were variable and in some cases plans need to be SMART.
- Management oversight and supervision was effective in some cases but in others were not compliant with the service/agency's procedures. There was a lack of scrutiny in some of the tools used.

Learning points:

- How can practice on obtaining and embedding the voice of the child and their lived experience be shared?
- There should be a handover from the health visitor to the School Nursing service as children move from one school to another where the child has been identified as being vulnerable.
- Good practice from the audit should be shared widely.

Recommendations

1. Partners to continue to improve case recording.
2. Children Social Care, to ensure that previous history of involvement is considered and accurately recorded in case recording.
3. Partners to ensure that the views of children, family members, including father is obtained.
4. Police to ensure that children are spoken to, including in welfare checks.
5. Practitioners involved in early help services to escalate cases where intended outcomes are not being achieved in a timely way, and to obtain feedback on concerns they have escalated.
6. CSC to ensure that there is an internal process for resolving disagreements between teams and that practitioners are aware of this process as well as the LLR LSCB Resolving Practitioner Disagreements and Escalation of Concerns procedure.
7. CSC to ensure that practitioners understand and apply the threshold for services appropriately so that children are provided with services according to their needs – where there are complex/chronic needs there is careful consideration in allocation of these cases to the most appropriate teams.

Further Information

LSCB Website | LLR LSCB Multi-agency Safeguarding procedures | LLR LSCB Resolving Disagreement and Escalation of Concerns procedure | Early Help Service

LSCB, Pratima Patel, Policy Officer – 06.04.2017