Key messages/learning from LSCB Multi-agency Case File Audits 2016-2017

Background

Working Together to Safeguard Children (2015) requires Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files. Audits were undertaken on behalf of the Board and focused on quality of multi-agency practice.

The audit included accuracy of case details, identification, referrals and response to the audit themes (i.e. neglect, CSE, FGM DV) and underpinning this was the voice of the child, compliance to procedures and early help intervention.

Themes audited

- Neglect
- Child Sexual Exploitation (CSE)
- Female Genital Mutilation (FGM)
- Domestic Violence/Abuse (DV)
- Pre-birth (unborn child)
- Early Help

Leicester, Leicestershire & Rutland LSCBs audits

In addition to the above, multiagency audits were conducted with the Leicestershire & Rutland LSCB on the following:

- CSE
- Neglect

LLR LSCB multi-agency safeguarding procedures:
http://llrscb.proceduresonline.com/chapters/contents.html

LSCB multi-agency safeguarding procedures:
http://www.lcitylscb.org/

Methodology

- Themes were identified by national/local SCRs, Ofsted thematic inspections, LSCB priorities & local practice issues and agreed by the Performance Analysis & Assurance Group and Board.
- Audit scope, sample, selection of cases, audit tool & timeline were discussed and agreed by the LSCB audit group representatives from:
  - Safeguarding Unit, Children's Social Care & Early Help Service
  - Leicestershire Police
  - Leicestershire Partnership Trust
  - University Hospitals of Leicester
  - Learning Services , Leicester City Council
  - Clinical Commissioning Group
  - LSCB
- Cases for auditing were identified by partner agencies and/or Children Social Care & Early Help Service.
- Audit discussion meeting (with the audit group & auditors) took place for each audit (theme) which informed the report and summary that was produced.
- Audit reports/summaries were submitted to Performance Analysis & Assurance Group, and findings were presented to the LSCB Executive Chairs group and Board.
- Audit summaries were widely circulated through the LSCB network and are available at: http://www.lcitylscb.org/information-for-practitioners/lscb-multi-agency-audits/

Key agencies asked to conduct the audits

- **Children's Social Care & Early Help (CSC)**
- **Leicestershire Police**
- **Leicestershire Partnership Trust (LPT)**
- **University Hospitals of Leicester(UHL)**
- **Learning Services, Leicester City Council**
- **Clinical Commissioning Group (CCG)**

Key messages: Overall there was pockets of good practice but there was a need to do more to improve practice to safeguard children and these are stated in key themes below	
Aspect/theme	***What do we need to do more of?***
Management oversight/supervision	**Our managers need to continue to support us and make sure that our practice is compliant to procedures and ensure that we are using tools/research to inform our practice to meet the intended outcomes for safeguarding children. They need to challenge our practice and offer reflective supervision to support and improve our practice.** *There was evidence of management oversight resulting in good casework practice but this was inconsistent.*
Recording full and accurate details	**We need to make sure that full and accurate details of child/family members are recorded.** *The audit identified instances where information, particularly around religion was missing, discrepancy in dates of birth and spellings of names as well as recording information in the wrong report.*
Compliance to procedures	**We all need to be aware of and work to relevant procedures that inform our work, including the LLR LSCB multi-agency safeguarding procedures to ensure that we are working to required standard and procedures. Our managers need to check that we are doing so.** *The audits identified evidence of compliance to procedures in some cases but not all and across the partnership.*
History of involvement	**What do I know and who should I talk to? We need to make sure that when working with child/families we are aware of and make a connection to all the previous involvement that has taken place within our service/agency and to record this accurately. We also need to share and be aware of, information held by partners to help develop a fuller picture. This is crucial as it informs current intervention and meeting of intended outcomes, and in some cases could reduce potential for drift and delay.** *There was evidence of the history of the child/family's involvement in some cases, but not all. In some cases there was insufficient exploration and connection to previous history to fully understand the current situation and the child's lived experience – impacting on meeting intended outcomes. There was also a lack of fully recording previous involvement resulting in gaps.*
Voice of the Child	**We need to embed the voice of the child and their lived experience (irrespective of their age) into our practice. This needs to be at the centre of our work with children/families. This means that we engage with children/families, including; very young children, those who require interpreters and their family members, including fathers.** *The audits found that engaging and obtaining the views of children/families, including the use of interpreters, was variable, with evidence of very good practice as well as poor practice in this area. Practice in involving fathers was inconsistent.*
Referrals	**We need to be aware of, understand and use the LLR LSCB Thresholds and provide comprehensive & key information when making referrals to Children's Social Care. Be aware of what is going to happen next in relation to safeguarding the child.** *The audit found that there was an understanding and application of the LLR LSCB Thresholds and timely referrals made in some cases, but this was not consistent. Children's Social Care needs to feedback their decision on the referral to the referrer and referrers need to obtain feedback, if not received.*
Assessments and Plans	**We need to make sure that our assessments are timely, robust and informed by relevant tools and research. They must include contribution from multi-agency partners and CYPF, and include SMART plans. These must be shared and understood by CYP and their parents.** *There was evidence in some audits of timely and robust assessment, use of tools/research and SMART plans, but not in all. There was a lack of awareness amongst practitioners within partner agencies that a single assessment conducted by Children's Social Care is actually a multi-agency assessment, which partners should contribute to.*
Multi-agency working and meetings	**We need to continue to work well together and ensure that multi-agency meetings are timely, key relevant practitioners are invited (with sufficient notice) and contribute to the meetings, and are administered well (accurate minutes/notes of the meetings are taken and distributed).** *Although good multi-agency working was identified in the audits, there were issues in relation to key partners not being invited, inaccurate recording of meetings and circulation of minutes/notes of the meetings. Plans were not always SMART and did not meet intended outcomes in some cases. Not all strategy meetings were compliant to procedures as there were some in which not all key partners were invited and plans were not SMART.*
Escalation of concerns	**We need to be aware of and use escalation procedures, including the LLR LSCB Resolving Disagreement and Escalation of Concerns procedure when we are concerned about a decision relating to safeguarding a child. Where we have escalated concerns we need to obtain feedback on the outcome of the escalation and be clear about what the interim safety arrangements are for the child.** *Escalation of concerns was variable - in some cases there was awareness of and use of escalation procedures but in others, there was lack of escalation or timely escalation. For example, in the early help audit in some cases, practitioners awaited the Multi-Agency Support Panel (MASP) to step-up a case rather than stepping up the case as soon as this was identified.*