SOLIHULL LSCB

MULTI- AGENCY CASE AUDIT REPORT

2018 - 2019

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Section 1: Introduction

1.1. Background

1.1.1. The Children Act (2004), places a statutory duty on partners to safeguard and promote the welfare of children. Local Safeguarding Children Boards (LSCBs) are required, as part of their statutory duties and functions, to quality assure the effectiveness of its members' practice.

1.1.2. In accordance section 14 of this Act, the LSCB has several statutory objectives and functions. These are:

(a) To co-ordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and

(b) To ensure the effectiveness of what is being done by each such person or body for those purposes.

1.1.3. This report relates to objective (b). Multiagency audits of case files that relate to specific themes are considered to be an effective way of providing the LSCB with information about the quality of work undertaken by professionals in relation to a specific child or group of children, particularly if practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made.

1.1.4. The multi-agency audit process has taken place annually since 2015, and is carried out by the LSCB multi-agency case audit sub-group as part of a rolling programme of quality assurance activity.

1.1.5. The themes of this audit have been linked to the LSCB key priorities, namely; the quality of early help, the impact of neglect, and supporting children who are suffering from exploitation.

1.2. Terms of Reference

1.2.1. The case audit sub-group manages the quality assurance functions of the LSCB. The chair of the group is Simon Stubbs, Head of Safeguards and Quality Assurance in Solihull MBC. The purpose of the group is to support Solihull LSCB to '*ensure the effectiveness of safeguarding'*. It does this by:

- Reviewing and agreeing a quality assurance framework including key lines of enquiry and accompanying standards based upon key themes of practice linked to the LSCB's key priorities.
- Setting out a cycle of auditing
- Undertaking multi-agency case auditing
- Regularly – at least annually- review the LSCB Quality Assurance Framework, particularly with regard to case auditing.
- Receive and learn from annual summaries of individual single agency case auditing- submitted to the QA group by agencies in April each year- together with the resultant learning identified and improvement actions undertaken and monitored within each agency.

1.2.2. Members of the group include representatives from the following organisations:

- Birmingham & Solihull Clinical Commissioning Group (CCG)
- Birmingham & Solihull Mental Health Foundation (BSMHF)
- Community Rehabilitation Company (CRC)
- Education and Early Years
- Solihull Children's Social Care (representatives from Early Help and Social Work Services
- Solihull Integrated Addiction Services (SIAS)
- South Warwickshire Foundation Trust (SWFT)
- National Probation Service,
- Solihull Community Housing (SCH),
- University Hospital Birmingham (incorporating Heart of England Foundation Trust (UHB- HoEFT)),
- The voluntary sector (represented by Young Carers)
- West Midlands Police (WMP)

1.2.3. Agency representatives are responsible for ensuring that audits are undertaken in a timely way, that learning is identified and agency actions plans are completed. Agency representatives are responsible for ensuring learning from the audits are fed back to relevant practitioners in their respective organisations and cascade learning and improvement actions to actively promote the better safeguarding of children within the area.

1.2.4. Partners hold each other to account for their contribution to the safety and protection of children, facilitated by the chair.

1.2.5. For the purposes of this audit, the definition of 'child' means those children who have received an early help service and/or where neglect and/or exploitation of that child has been identified between or 0-18, and those who as a result of this are still eligible for support until they are 25 (e.g. care leavers).

1.2.6. The LSCB uses the finding from the audit activity to identify priorities that will improve multi-agency professional practice with children and families. The chair raises challenges and works with the local authority and other LSCB partners where there are concerns that the improvements are not effective.

1.2.7. Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. The experiences of children and young people are used as a measure of improvement.

1.2.8. The group meets 6 times per year and the meeting dates are organised to support the auditing and QA activity.

Section 2: Audit Methodology

2.1 Aims of the audit process

2.1.1 The audit activity aims to help shape priorities through identifying areas of good practice and areas of improvement. The audit process is based around 10 key steps delivered over a 12 month cycle. The audited cases were selected randomly against the three LSCB priority areas, using an agreed set of criteria determined by the audit sub-group.

2.1.2 The 3 LSCB priorities for 2018/19 are:

- To support the delivery of Early Help services
- To promote positive and promising practice on neglect, and gather evidence of the impact
- To help children at risk of exploitation and provide support into adulthood.

2.1.3 The purpose of the audit activity is to gather data focusing on the experiences of children, families and practitioners against the key priorities. This data then informs learning for each agency across the partnership and helps to improve outcomes for children in the Solihull area. The findings also shape the LSCB Learning and Improving Framework.

2.1.4 The audit aims to identify strengths, areas for improvement and lessons to be learned for individual agencies and also in multi-agency working.

2.2 Processes used to audit

2.2.1 The methodology used for the previous 2016/17 & 2017/2018 audit cycles was refined and adapted using the auditors' experiences to promote ease of use by auditors and to facilitate the aggregation of data to inform the evaluation process.

2.2.2 The Key Lines of Enquiry (KLOE), were reviewed and the audit group felt that they were still relevant and appropriate. KLOE 1 and KLOE 2 were swapped to better reflect case progression but in general the KLOE remained the same as for the previous years' audits in order to provide a view about the impact of previous learning. This is the fourth year that these KLOE are being used. Each standard underpinning the KLOE was also reviewed by the case audit group and changes were made to some standards to refine them and make their meaning more clear. An additional standard was also added (*Standard 14: Where there are complex needs/multiple plans in place, professionals are aware of their roles and responsibilities*).

2.2.3 Auditors were asked to audit the selected cases and reach a view as to whether the agreed standards had been met, exceeded or unmet for each KLOE. Twenty-four cases were identified (8 for each LSCB priority) for audit with children of the following ages:

Age	2	4	5	7	11	12	13	14	15	16	17	18	21
Number	2	2	2	2	2	2	2	2	1	2	3	1	1

2.2.4 Each organisation represented on the Case Audit sub-group carried out an independent audit using the template/tool defined and agreed by the case audit sub-group.

2.2.5 In addition, a mock Joint Targeted Area Inspection (JTAI) process was added to the 2018/19 audit process. This was based on learning from the previous year's cycle where the sub group carried out a 'deep dive' round table discussion in respect of a small number of the 24 cases selected for audit. It was felt that this would add a different level of feedback about multi agency working.

2.2.6 The mock JTAI exercise took place in May 2018; the summary of the learning from this activity can be seen in Appendix I. This was also presented to the LSCB Executive group in June 2018 as well as being shared at the learning event in November 2018.

2.3 Evaluation of the process

2.3.1 Each agency representative was asked to collate the information obtained and deliver a presentation on their agency's audit findings at a learning event held in November 2018. The event was the second to be extended to a full day after feedback from the previous years' audit cycle. Practitioners were provided with a slide template for their presentation to facilitate consistency of approach.

2.3.2 The process itself is relevant to safeguarding and agencies could clearly demonstrate where there had been learning in respect to each KLOE and standard, or where the quality of practice had declined.

2.3.3 A table top activity (using a Signs of Safety approach) was undertaken at the learning event following the presentations. The amalgamated feedback is set out in Appendix III – Feedback from Learning Event.

2.3.4 Whilst the auditing process against the same KLOE and standards provides for consistency, and the membership of the case audit group remains stable, there are still some inconsistences in how agency representatives undertake the audit process. Some agencies complete the audit stating a standard is simply met or not met; other agencies complete the audit template with some evidence to justify their findings. In some cases, auditors will accept a standard is met based on evidence from a practitioner, but in other cases auditors will only accept that a standard is met if this is evidenced on the record.

2.3.5 Thus far, it has not been possible to cross check data to ensure consistency in auditing. For example if one agency feels standard 13 is met (i.e. The plan is SMART and another agency states that the standard is not met. In part, this is due to the differing methods of identifying cases (tribal ID, CareFirst ID, initials). To some extent this is ameliorated by the deep-dive auditing but quality assurance of auditing is being considered for the next cycle.

2.3.6 One agency did not use the toolkit to record their audit and did not use the slide template to feedback to the sub-group. However, audits were undertaken and learning was gleaned from these, which is positive, but the sub-group members are clear that there needs to be consistent processes used to maximise learning. One agency did not consistently use the current toolkit, and alternated with last year's template, which meant that standard 14 wasn't captured in all cases and that comparisons between last year's learning and this year's learning is not as complete as it would otherwise have been.

2.3.7 Because one of the themes that was the focus of the audit was exploitation, it meant that this cohort of children were in the upper age range (teenagers).

Section 3: Analysis of Findings

3.1 Brief Overview

3.1.1 Overall, in almost every standard, where the data is available and comparable, there has been an improved picture. However in some areas improvement work is needed to sustain to further improve services' response to children at risk of harm

or in need of early help. It should be noted that these are *the draft findings and as such are yet to be ratified by the agencies involved.*.

3.2 KLOE 1 - Do practitioners have the knowledge to correctly apply the thresholds and referral processes to support effective and accountable practice?

3.2.1 Evidence confirms that practitioners from the majority of agencies are aware of the threshold guidance, are able to locate the document on the LSCB website or have access to a current copy. The audits demonstrate that practitioners are able to use this guidance to support the making of high quality, evidence based referrals. Practitioners generally reported that the new referral form for Children's Services is structured in such a way as to make referrals more appropriate. It is noted that this audit has not provided any evidence of any out of hours referrals to Children's Social Care.

3.2.2 The data shows that practitioners are recording when they are obtaining consent. In the majority of cases consent is sought in appropriate circumstances and this is explained to families and this seems in line with the data from the previous cycle of auditing. However with new GDPR there may be a need to review policies and procedures to check that consent is only sought when legally required.

3.2.3 Feedback from practitioners indicate that where a referral has been made feedback is being received and these discussions are helping embed threshold understanding.

3.3 KLOE 2: What is the quality of information sharing, both within, and between, relevant multi-agency meetings?

3.3.1 In the majority of cases, relevant partners are identified in a timely way and are appropriately engaged. There was an example of 1 agency not being informed about a child in need plan, and there is need to strengthen early help processes so that there is a consistent approach across the board as this will help appropriate practitioners to be identified and involved.

3.3.2 On the whole, practitioners have demonstrated that they are aware of, understand, and apply information sharing protocols including applying data protection law and citing Working Together guidance or KCSIE.

3.3.3 For the majority of multi-agency meetings practitioners review the evidence, prepare reports (using the relevant template) and actively contributes to meetings, however more focused policies and procedures are needed for multi-agency early help and non-social care multi-agency meetings (i.e. YOS).

3.3.4 In the majority of cases there is evidence that records of the child protection or child in need meetings have been kept, with relevant actions, and that these have

been communicated to partners and families where appropriate; this represents a change for the better in practice, as this was an area of weakness in last years audits. It remains an area that is less strong for early help.

3.4 KLOE 3: Is it evident that the voice of the child has been heard?

3.4.1 There is evidence to show that many practitioners have considered what life is like for the child, although this is easier and more evident for those services that work directly with children rather than adults. The child's wishes and feelings are being creatively gathered, there is evidence that their experiences are being understood and practitioners working directly with children were able to articulate their specific needs; however the recording of children's views and including these in analysis and assessments varied and can be improved.

3.4.2 Diversity and disability issues are appropriately identified, understood, addressed and recorded in most cases.

3.4.3 Practitioners working with children are able to articulate how the voice of the child has shaped their intervention; in one service there has been an innovative way of bringing children and adult practitioners together to help understanding of the child's lived experience.

3.4.4 In respect of the wider exploitation cases, services often sought the views of children, who, due to their experiences of exploitation, did not engage or whose stated views were different from what professionals felt was in their best interests. This represents a dilemma which needs some form of resolution.

3.5 KLOE 4: Are interventions working effectively to improve outcomes for the child?

3.5.1 Following on from the previous paragraph, again the outcomes of interventions were deemed less effective for children who were identified as 'entrenched' in forms of exploitation. In the majority of cases, work was completed to a very high standard, but has not been effective in making significant changes to the child's safety. Again, this represents a significant dilemma in respect of multi-agency practice.

3.5.2 SMART plans are important because without these practitioners and families struggle to understand what needs to be completed, who is taking responsibility There was an overall increase in SMART plans being evident but there is still room for improvement across all agencies. Where plans were not SMART it was identified that reviews were less effective because practitioners (and families) were unable to identify who 'owned' particular actions in the plan, or where actions were not clear, unrelated to an outcome or where no timeframe had been set to

ensure outcomes were timely. In several cases the plans audited were single agency not multi-agency plans.

3.5.3 The use of specific tools and frameworks was highlighted as a general strength. In particular the use of Signs of Safety as a framework was identified as an area which benefitted families and practitioners. Again, some tools could be embedded more thoroughly and their use be monitored. In some cases, tools (such as graded care profile) could have been used to support practice but were not. In other cases tools were used, but not as well as they could have been (e.g. signs of safety not being used appropriately, poor danger statements). Where the tools were being used appropriately, there was evidence that the impact of interventions were more easily measured and that where positive outcomes were not being achieved in a timely manner actions were taken to mitigate the risks to the child.

3.5.4 Work around child sexual exploitation is general embedded well. Practitioners largely have good understanding around this area of work but there is a need for policies and procedures and a screening tool to be developed for wider exploitation. Work is also needed to check if the Domestic Violence Risk indicator Matrix (DVRIM) and/or Domestic Abuse, Stalking and Harassment (DASH) assessment could enhance multi-agency work in domestic abuse cases.

3.5.5 Disguised compliance and parental non-engagement is generally recognised and acted upon; however this can take time to recognise and sometimes is not immediately apparent. Robust use of Signs of Safety and scaling could help to address this, but only if the safety goals and accompanying actions are SMART.

3.6 KLOE 5: Is supervision/management support used to aid reflective practice and to provide challenge to make a positive difference for the child?

3.6.1 Supervision appears to happening at minimum frequency of every 3 months in line with the LSCB requirements. Agencies appear to have a number of different models of supervision, but there appears to be consideration of the child in decision-making. Practitioners confirmed they experience supervision as providing an opportunity to reflect, to receive professional challenge and to be supported in providing challenge to others, although this wasn't always evident in case recordings. Peer supervision or case learning meetings may also help this process by enabling multi-agency practitioners to reflect on a case as a group.

3.6.2 In the majority of cases the supervision process evidenced management activity that is focused on ensuring practice is competent and compliant with local expectations and requirements. Children were discussed according to their individual needs in most cases. There are opportunities for agencies to learn from each other regarding effective supervision. Again, the 3 columns framework from

Signs of Safety came across well as a framework for recording supervision where this was implemented.

3.7 KLOE 6: Are practitioners resolving professional disputes/disagreements in line with the dispute resolution procedure?

3.7.1 The audit activity shows that most practitioners are able to articulate they are aware of the dispute resolution procedure and where they can locate it. The majority of services felt there was not an occasion where an issue has arisen to use these procedures, however 1 agency found that partners should have used these procedures on one occasion when they failed to respond. Another identified at one point that non-response from an agency should have been escalated, but didn't include this in the dispute resolution section.

3.7.2 Feedback from presentations at the learning event indicates that dispute resolution is happening informally between practitioners and therefore people did not routinely need to use the template of log disputes with the LSCB.

3.8 Overview of findings from wider exploitation deep dive audit - Mock JTAI

3.8.1 Following on from the success of the deep-dive audits in last year's cycle, the sub-group felt there was a benefit to repeat the deep-dive activity using the framework from a Joint Targeted Area Inspection. The theme of the deep-dive audit activity was wider exploitation (Child Sexual Exploitation (CSE), children associated with gangs and at risk of exploitation and children missing from home, care and education).

3.8.2 The deep-dive audit looked at 8 cases where children met this criteria. The findings in respect of this are set out above and in detail in Appendix I. The audits evidenced that cases of children and young people being exploited or who are at risk of exploitation are very complex in nature. The majority of children/ young people who were included in this part of the audit experienced multiple problems (e.g. exposure to domestic abuse, poor school attendance/exclusions and disability).

3.8.3 The multiplicity of need seems to contribute to the complexity of case management. In some cases, numerous professionals were working with the family who were then experiencing multiple meetings, plans and visits and appears to have contributed to families' disengagement. Consideration needs to be given to co-ordinating plans and meetings to make them more accessible for families.

3.8.4 As stated above, the response to CSE seems to be well understood and risk generally is appropriately identified in cases of wider exploitation. Practitioners across the board struggled more with how to respond appropriately to the risks once they are identified. In most cases work appeared to have been undertaken with the aim of reducing risk, but in some cases this had not been effective to reduce risk. We therefore need to consider how we can support practitioners in finding different ways in engaging with young people who are at risk of exploitation. Where work had been effective, continuity of relationships with workers seemed to be a strong contributory factor to reducing/ managing risk.

3.8.5 Action was taken as a result of the deep dive to address concerns on two cases. It should be noted that that the concerns in the cases were replicated because the two young people in question are siblings living in the same home.

Section 4: Conclusions and Recommendations

4.1 What worked well

4.1.1 In this section, we will consider the process and the amalgamated findings of the audit process.

4.1.2 Regarding the process, the following worked well:

- The timeline and cycle were clear and provided clarity as what activity was happening
- The commitment of the agencies involved is to be applauded, as is the dedication of the agency representatives.
- The introduction of family feedback to inform the audit process was welcome, although we need to consider the most appropriate way of scaling this up and making the feedback more meaningful.
- Using the deep-dive process to prepare for a potential JTAI was a good use of time and allowed the multi-agency group to develop more knowledge of those cases. This activity was valued by the audit group.
- The feedback from the learning event was positive in that agency representatives felt there was value in the day and that learning can be brought back to their respective organisations. It is evident through this audit that practitioners in Solihull demonstrate good practice and agencies involved are committed to identifying both what they are doing well, and areas for improvement.
- There has been consistency in the membership of the audit group over a period of time and therefore learning has been embedded across agencies.

- The commitment of the audit group members and the support of their agencies to undertake audit activities has greatly contributed to the overall success of this cycle.

4.1.3 Regarding the findings from audit activity, the following positives were acknowledged:

- Areas of improvement highlighted in previous audits have either been addressed, or progress continues to be made to do so.
- There has been a continual improvement in the general understanding of thresholds and application since the last round of audit activity.
- Consent issues seem generally well understood.
- Where practitioners were involved with children directly, they were able to speak authoritatively and knowledgably about their cases and about the experiences of the children with whom they are working.
- Risks seem to be identified and where concerns were identified in respect of practice, the auditors acted to address the concerns within their agencies.
- The audits indicate that professionals are involved/ receive appropriate information from meetings and generally received feedback from referrals where these have been made.

4.2 What needs to be improved

4.2.1 Agency representatives need to be more consistent in completing the process to allow for better understanding across the multi-agency partnership. It should be noted that this is more focused on refining the process to improve what we are already doing, as opposed to re-working the processes in place. Progress has been made in raising awareness of the dispute resolution procedure; however there is more work to be undertaken to inform the understanding of its correct use.

4.2.2 For the first year it was decided to try and gain feedback from families whose cases have been audited, and this is work to be progressed next year to improve the response rate and make it even more meaningful.

4.2.3 In terms of practice, there was recognition across the audit process that the following learning or improvements need to be considered:

- There is some indication that when problems in multi-agency interactions occur, practitioners can generally resolve this without formal recourse to the dispute resolution process; however there are times when practitioners did not act (for example following up on a referral they have made) to provide appropriate challenge.
- The response to multiple needs must be considered, so that plans are more cohesive for families and families do not become overwhelmed. This is

particularly true for cases of wider exploitation, but may well have wider application.

- The findings from the JTAI have supported the need for the work already started by the LSCB to agree a definition for wider exploitation and to develop policy, procedures and screening tools to inform this work and enhance the understanding of contextual safeguarding.
- Progress has been made in raising awareness of the dispute resolution procedure; however there is more work to be undertaken to inform the understanding of its correct use and support practitioners to use it.
- Although information sharing is generally positive, minutes from multi-agency meetings are not always sent in a timely manner to GPs who cannot attend.
- Supervision and managerial oversight appears to be stronger than previous cycles and agencies could potentially learn from one another's practice in this regard.
- The Signs of Safety framework was cited in several presentations as being helpful to organise practitioners' thoughts and support more robust analysis.
- Multi-agency processes and policy (including, for example, meetings) need to be further developed for Early Help and Youth Offending.

4.2.4 Regarding the findings from audit activity, the following areas for improvement were identified:

- There is potential for confusion regarding the need to seek consent (specified in Working Together 2018) and the circumstances with which consent can be dispensed with (GDPR). This needs clarifying by the partnership.
- Inclusion of GPs in meetings they cannot attend still needs more work.
- Early Help processes need to be developed and more rigorously understood with regards to assessments, record keeping and inclusion of others.
- Work needs to be undertaken to support practitioners to confidently intervene where they are concerned about exploitation.
- SMART planning needs to continue to be strengthened.

4.3 Summary and Recommendations

4.3.1 The 2018-2019 case audit cycle has been successfully completed. The overarching picture against the Key Lines of Enquiry is one of generally positive single and multi-agency practice. The evidence suggests that in many areas there has been further improvement against KLOE when compared with the findings of the audit process during the previous year, showing a continuing growth in the quality of practice despite the challenges across all agencies of increasing demand in a time of tighter resources.

4.3.2 It is evident through this audit cycle that practitioners in Solihull are delivering positive and effective practice in relation to children. Organisations have demonstrated that they are keen to identify both what they are doing well, and what they could look to improve on. Feedback at the learning event evidenced that each agency had reflected upon their audits and put in place actions to further improve practice within their own agency and across the partnership. Examples include SIAS bringing together adult and child- focused workers to inform family working and Children's Services reviewing and changing the referral template to support better referrals to children's social care.

4.3.3 We have the following recommendations about the process:

- A briefing/training session to be delivered to all agency representatives to support more consistent styles of auditing and to ensure consistency in the delivery of results.
- A QA process to be introduced in the next cycle: This could be looking at the same cases and comparing findings against each standard post audit, or joined up auditing where a member from a different agency undertakes the audit alongside the agency representative.
- Refine the family feedback process by liaising early with the lead worker to determine the best approach.
- The findings from this audit process should be shared at the next Executive Group for decisions as to how the findings from the audit will shape the priorities and business of the safeguarding partnership in the future and how learning can be embedded.
- The report is also shared with the Solihull 'Troubled Families' lead for consideration of learning in relation to a 'whole family' approach.
- The LSCB Case Audit Group is responsible for securing feedback from managers in relation to the result of the assurance questions exercise.
- Solihull LSCB Business Unit amends the JTAI audit tool and sharing learning in relation to the process (but not the findings) with other local LSCBs/ Safeguarding Partnerships.
- Next audit should consider practitioners' understanding of the impact of traumatic childhood experiences and methods of ameliorating the on-going effect of these experiences for families, including how to intervene in cases where multiple complex needs are identified and where children are being exploited in the community.

4.3.4 The conclusions in relation to quality of practice have been greatly enhanced through the introduction of the 'deep dive' discussion element. This addition was valued by the auditors. The evidence from case audit process has should be considered in order to inform the LSCB improvement plan.

4.3.5 Recommendations in respect of practice are set out in appendix III: Overall, the 2018/19 case audit was successful in identifying areas of both good practice and development. The 2018/19 multi-agency case audit cycle has been successfully delivered, auditing 24 cases this year. This could not have been achieved without the consistent commitment and dedication of the agency representatives on the sub group, or, without the commitment of the various partner agencies in freeing up these staff members to prioritise their time for this activity. In such financially challenging times this is commended and appreciated by the LSCB and the sub group Chair.

Appendix I – Mock JTAI

Solihull Local Safeguarding Children Board

Case Audit Group

JTAI Exercise – Child Exploitation

May 2018

Background

An additional round of JTAI inspections was announced earlier this year. These will be focusing on the theme of CSE, children associated with gangs and at risk of exploitation and children missing from home, care and education.

Should Solihull be subject of a JTAI inspection it is important that both individual agencies and the LSCB have plans in place to provide the necessary information to inspectors and conduct the audit activity promptly. As such, the plans that have previously been developed in readiness for JTAI inspection have been revisited and updated. In addition the local audit tools for use in any JTAI inspection have also been revisited and updated in light of the most recent guidance.

The current JTAI theme fits well with Solihull LSCB's recently agreed priority focusing on children and young people at risk of broader forms of exploitation. It was therefore recognised that it would be of great benefit both to the understanding of the effectiveness of the current multi-agency arrangements in Solihull in relation to dealing with other forms of exploitation, and also to test our preparedness for a JTAI inspection by using the refreshed audit tool, to bring together partners to conduct a multi-agency audit process on selected cases involving child exploitation using the JTAI audit method.

Methodology

This exercise was completed via the Solihull LSCB's Case Audit Group. In recognition of the impact on partner's time and commitment to audit work, the results of this JTAI exercise will be fed into the annual Case Audit Review work as part of the overall case audit activity for that group. It was not therefore an additional commitment.

The individual agencies represented on the Case Audit Group were each sent the agreed JTAI audit tool and a list of eight cases selected from Children Social Care records. In reality case selection would be completed by the JTAI inspection team from a larger list of cases supplied to them. The audit tool

was completed for each case with which they had involvement and returned to the LSCB Business Unit. A short completion date was provided to replicate as far as possible a JTAI process, so allowing individual agencies the opportunity to test their own plans for responding to such an inspection.

On 15 May 2018 practitioners from the different agencies met to conduct the multi agency element of the audit, as required within a JTAI inspection. An initial report covering the findings was presented to the Case Audit Group on 23 May 2018. Additionally, immediate learning was shared with relevant agencies where appropriate.

Single Agency Responses

There were many examples of good practice within individual agencies when responding to and managing these cases. There were also areas of development identified for single agencies. These areas are known to the agency representatives within the LSCB Audit Group, and will be followed up by them.

Multi-Agency Findings

The multi-agency audit day was well attended with excellent commitment from all attendees to a thorough and open examination of agency involvement. Seven of the eight cases were discussed, with the eighth case having insufficient information available to allow proper auditing.

The audit exercise resulted in the group identifying the following themes;

1. Cases of children and young people being exploited or at risk of exploitation can be incredibly complex and multi-faceted and the challenges they present to the practitioners involved should not be underestimated.
2. Generally risk was identified well, particularly in the context of CSE. The areas for development lie more in strengthening our response to risk once identified, and associating the ability of all agencies to link child criminal activity with the potential for it to be as a result of an exploitative relationship with another.
3. The continuity of support worker and the strength of relationship between them and the child/young person was a vital part of keeping the child or young person safe. One case in particular highlighted this, although it was an isolated example.
4. Attention needs to be given to the co-ordination of various meetings, particularly within the more complex cases. There was reference to many different meetings taking place, but a lack of evidence as to the

co-ordination of their aims, and shared contribution to keeping the child/young person safe.

5. Linked to point 4 above, it was evident to the Audit Group that the demands being placed on families by the number of agencies engaged with them, each delivering their various responsibilities, could be onerous. There was evidence that this was a contributing factor to disengagement of the family with services. This was particularly the case when considered in the context of these families having disorganised lifestyles and other siblings/family members with separate or related needs, including special educational needs and/or disabilities, and potentially a mistrust of statutory agencies to begin with. This presents opposing challenges for agencies, as all agencies were striving to deliver a high quality service in line with their safeguarding responsibilities, however the implications to the child/young person and family willingness to work with them was potentially undermined by this.
6. A 'whole family approach' is required to tackle child exploitation. This would support both the need to consider how we identify and manage the potential risks to siblings of being drawn into exploitative situations, and a better understanding of the 'push/pull' factors that exist for a particular children/young people resulting in them being exploited.
7. The need to learn from our CSE screening processes, and use the well established nature of these to improve the identification of wider exploitation risks. Linked to this, we need a common understanding and language between agencies for how we identify those broader exploitation risks.
8. The need to recognise the impact of the child's background on their susceptibility to exploitation, and seeing that through the child's eyes. The use of an ACEs (Adverse Childhood Experience) model to assess that vulnerability and to build a better understanding of that child's experiences was suggested.
9. The need to develop a range of different options for practitioners to consider when approaching children/young people who are not engaging. There was evidence of the same approach to children, young people and families being used on a number of occasions despite that not achieving the desired co-operation.
10. A number of the children/young people suffered from conditions such as ASD/ADHD. The issue of where the young people get support in managing their condition, and how and by whom the taking of their medication is monitored was identified, including any link to the Education Health and Care Plan. It was important for health needs and

requirements, together with clear responsibility for provision to be specified, as it was apparent that these conditions if unmanaged increased the young person's risk of exploitation through their own behaviours.

Learning for Future JTAI Process

In addition to assessing the current effectiveness of the multi-agency response to child exploitation in Solihull, this JTAI exercise also gave the Board the opportunity to test the plans in place to fulfil the requirement of any JTAI inspection team to complete a multi-agency case audit and submit a report on findings as part of that inspection. The following areas of improvement in the audit tool and process were identified;

- Each case was given a grading by the audit group in line with the Ofsted grading system. This was found to promote considerable debate, which in such a time limited process perhaps detracted from the ability to focus on examining the information available and what it was telling the group about the quality of the multi-agency response. It is not a requirement within a JTAI process to provide such a grading, and it will therefore be removed from the process.

- It was identified that for some agencies the required information was actually held by partner agencies within neighbouring areas. In view of the very limited time agencies would have within a JTAI inspection to complete their own audits, any delay in acquiring this may present problems. As such, it is important that partner agencies in neighbouring areas are aware of the necessity of this co-operation in any JTAI inspection, and this learning will be shared with our neighbouring Boards.

- The audit tool that has been designed for use in a JTAI inspection was found in certain aspects to be too inflexible when trying to capture the learning and outcomes from the multi-agency audit discussions, which when working well moved freely between audit areas. The tool will therefore be revisited and updated.

Response to Identified Themes

There were two cases within the audit which were particularly complex. They relate to two siblings at risk of a number of forms of exploitation, with intelligence in relation to CSE, gang association, and trafficking. Agencies have been working with this family over a number of years, albeit engaging with both the children and their mother has presented challenges. Both children have been involved in criminal activity, there is domestic abuse and

potentially neglect within the family home, disability, school exclusions, potential risks from another family member, and a young child in the home.

These two cases were audited by the group and as a result of the examination of the single agency audit returns and subsequent discussions, the audit group concluded that from the information available to them, they could not be reassured that either child was safe. There were a number of reasons for this collective view, and these have been discussed with team managers directly in order to inform an immediate review of these particular cases.

The audit examined a relatively small number of cases, and so it was important to identify whether the themes identified in relation to these two cases are also present in other complex exploitation cases within Solihull. To identify and address any existing risk in similar cases, and disseminate the learning from this audit process at the earliest opportunity, a set of specific questions were developed which can be applied to other such complex cases where exploitation is involved. The question set is included as Appendix 1.

Managers have been requested that they use this question set to reassure themselves that any learning has been transferred to similar complex cases currently being managed by their teams where exploitation, or the risk of exploitation may feature.

Conclusion

Although immediate action was required in relation to two of the seven cases audited, both of these cases were within the same family and it is therefore important that this should not be used as an overall indicator of the proportion of cases held across the wider partnership which may require such action. It is also important to note that the audit sample of seven cases is small.

Overall, referrals were made in a timely manner and included sufficient detail to help aid decisions. There were however examples in which there was a delay between an initial referral and action taking place. This highlighted the need for practitioners to follow up the outcome of a referral if they have not been informed.

There was evidence that the risk of CSE is well understood and responded to appropriately. Perhaps unsurprisingly however, it appeared that the risk of

other forms of exploitation had in some cases been overlooked, with focus solely on sexual exploitation.

In the majority of cases the voice of the child has been heard and suitable attempts have been made to engage the children. However, it is clear that engaging these children and young people can be particularly challenging, especially in cases of older children. We therefore need to consider how we can support practitioners in finding different ways in engaging with young people who are at risk of exploitation.

Recommendations

1. The findings from this audit process are shared at the next Solihull LSCB Executive Group for decision as to lead for implementation of learning.
2. This report is also shared with the Solihull 'Troubled Families' lead for consideration of learning in relation to a 'whole family' approach.
3. The LSCB Case Audit Group is responsible for securing feedback from managers in relation to the result of the assurance questions exercise (Appendix 1).
4. Solihull LSCB Business Unit amends the JTAI audit tool and sharing learning in relation to the process (but not the findings) with other local LSCB's.

Stephen Eccleston
Interim Business Manager
Solihull Local Safeguarding Children Board
6 June 2018

Appendix II

Comparison of findings against 2017/18

Table 1	**2016/2017, 2017/2018 and 2018/2019 Performance Comparison**	
2016/2017 Areas of development	Progress noted in 2018/2019 audit activity	2018/2019 area for development
To ensure the right agencies are involved in multi-agency meetings and that there is consistency in record keeping and minutes of meetings.	The majority of practitioners report that they are receiving invitations to the appropriate meetings and conferences; the use of Signe of Safety (SOS) in CP Conference processes mean that a summary of discussion and the outline plan is shared at the end of the Conference; there is less consistency in child in need and early help	There is a need for clear multi-agency procedures for assessment, intervention and planning for early help and non-social care interventions i.e. YOS to ensure all professionals can be engaged from the start and understand their roles and responsibilities.
Areas for development for 2017/2018		
Work to ensure that, where possible, practitioners are freed to attend meetings they are invited to. Continue to work to ensuring that minutes of multi-agency meetings have an appropriate level of detail and are distributed promptly.		
2016/2017 Areas of development	There was clear evidence that the feedback received from referrals is aiding peoples understanding and further implementation of thresholds. There was no specific reference to out of hours work	Monitor that referral feedback continues to be positively received as Childrens services structures changes in 2019-2020 Is there a need to check out of hour's response?
To continue to make progress in the receipt of feedback from referrals.		
Areas for development for 2017/2018		
Continue to ensure all organisations receive feedback about referrals made. Review the with professionals the impact of the introduction of the revised on-line referral process for Children's Services		
2016/2017 Areas of development	All organisations report that the majority of practitioners are aware of the threshold guidance, and know where to find it.	There is a requirement for guidance and procedures about wider exploitation and contextual safeguarding to be incorporated into the threshold document when agreed.
Using the threshold guidance in practice		
Areas for development for 2017/2018		
Ensure new members of staff are familiar with the threshold guidance, know where to find it and are supported to understand how they apply to particular circumstances.		
2016/2017 Areas of development	There was evidence of a better recording of when consent has been gained, but there is some confusion of when consent is need	Review of multi-agency and single agency procedures against GDPR to clarify that consent is only being sought when legally required
Clarity across agencies regarding the requirement to obtain consent.		
Areas for development for 2017/2018		
Work to further improve the frequency and robustness of the recording of the rationale used in cases where it is considered that a referral should be made without first seeking consent.		

2016/2017 Areas of development Gathering the child's wishes and feelings and ensuring all agencies take account of this Areas for development for 2017/2018 Continued progress is needed within agencies that do not routinely have direct contact with the child to promote keeping the child in mind.	The use of signs of safety has strengthened the voice of the child in CP work, as does the use of specific tools; three houses, GCP2 when they are used etc. There is evidence provided of practitioners being creative and flexible when attempting to engage the child. This is a difficult area for adult focused services to evidence	To ensure the voice of the child is accurately recorded and reflected in assessments SIAS have used an innovative way to bring their children & adult service practitioners together in reflective learning which has helped strengthen the voice of the child & understand their lived experience- look at ways to share this type of innovative practice
2016/2017 Areas of development Continued work is needed in terms of SMART planning, contingency planning, and the continual re-assessment of interventions to have a positive impact on the child Areas for development for 2017/2018 Continue working to ensure the presence of a contingency plan in the event that expected progress is not evident. This should include situations where family member engagement with the plan reduces or is not forthcoming.	There is evidence of increased use of signs of safety and tools like GCP2 to aid engagement and understanding, but they are not yet consistently used- Not all plans are SMART, so this can make them more difficult to review. There was some evidence of FIB forms being completed There is less evidence of DVRIM/ DASH tools being used	GCP2 needs to be embedded in practice as early as possible. Agree the definition of wider exploitation and implement appropriate multi-agency policies and procedures including the development of a wider exploitation screening tool Actively looking for FIB form submissions when intelligence is recorded should be included in future multi-agency audits Future audits should look to see if DVRIM/ DASH tools could aid multi-agency communication, understanding and intervention. A wider understanding of Adverse Childhood Experiences (ACES) may help understanding of parental difficulties and engagement
2016/2017 Areas of development Improvements in the frequency of supervision sessions. Previously the audit highlighted that sometimes supervision does not take place as often as planned. Areas for development for 2017/2018 Ensure that obstacles, such as staff absence and sickness do not cause a breakdown in regular supervision sessions. Ensure supervisions are effective, offer respectful challenge and the opportunity for reflective discussion.	There is a strong sense that there are supervision processes in place and that practitioner's value the support and supervision received, there is inconsistency in appropriate recordings of supervision in case notes. There was some recognition of case learning meetings and that these could have a use to help multi-agency practitioners to reflect on the cases they are working.	Actively promote and audit for the use of Case Learning Meetings in all multi-agency work Supervision is different in each agency- are there opportunities to share and explore the benefits of different models?

2016/2017 Areas of development Further promotion of the LSCB Dispute Resolution Procedure to embed this in practice Areas for development for 2017/2018 Continue to raise awareness of the procedure Strengthen understanding of the procedure so individuals feel confident using it. Look to making the procedure more visible on the LSCB website	There appears to be evidence of practitioners being to verbalise their awareness of the procedure and where to find it. However there was no evidence of the procedures being used in the cases audited, although 1 agency strongly advocated they thought that partners should have used them when they did not respond to a request.	The question of if people are resolving professional disputes early without the need for the procedures, or if there is a “fear / lack of understanding” of using the procedures needs to be explored in future audits.

Progress against findings of 2016/17 and 2017/2018 Audit

The progress against the areas for development identified within the 2016/2017 and 2017/2018 audit, and the main areas for development identified as a result of the 2018/2019 audit are summarised in Table 1 above.

Recommendations:

- The findings from this audit process shared at the next Executive Group for decision as to lead for implementation of learning.
- The report is also shared with the Solihull 'Troubled Families' lead for consideration of learning in relation to a 'whole family' approach.
- The LSCB Case Audit Group is responsible for securing feedback from managers in relation to the result of the assurance questions exercise.
- Solihull LSCB Business Unit amends the JTAI audit tool and sharing learning in relation to the process (but not the findings) with other local LSCB's.

Conclusions

Overall, the 2018/19 case audit was successful in identifying areas of both good practice and development.
The 2018/19 multi-agency case audit cycle has been successfully delivered, auditing 24 cases this year. This could not have been achieved without the consistent commitment and dedication of the agency representatives on the sub group, or, without the commitment of the various partner agencies in freeing up these staff members to prioritise their time for this activity. In such financially challenging times this is commended and appreciated by the LSCB and the sub group Chair.

Appendix III – Feedback from Learning Event

KLOE 1: Do practitioners have the knowledge to apply correctly the thresholds and referral processes to support effective and accountable practice?

Standard 1; The practitioner is aware of the threshold guidance, knows where to find it and demonstrates that they are able to use this guidance to support the making of high quality, evidence based referrals in this, and/or in other cases. For example, out of hour referrals.
Standard 2; The practitioner is clear about the requirement to obtain consent.
Standard 3; Consent is sought in appropriate circumstances and this is explained to families
Standard 4; Where a referral has been made by the practitioner's agency in relation to the case, feedback has been received, and where it has not been the practitioner has taken action to pursue this.

What are we doing well?	**What needs to happen?**
Generally there is a good awareness of there being a threshold document and understanding thresholds is improved by feedback on referrals from MASH rep. Better professional challenge Supervision helps identifying gaps Better recording of consent	Support mapping of exploitation cases against threshold document Training re contextual safeguarding and the impact of wider societal issues and ACE's Look at procedures in individual agencies- is consent still being referred to where it is not needed (GDPR) Multi-agency workshops looking at how thresholds are met; why some don't examples Increase conversations with MASH prior to formal referrals. Professional challenge & conversations Include thresholds in inductions to all staff Ensure content is reviewed Develop an exploitation tool that helps mapping against threshold
What are we worried about? Are thresholds re wider exploitation understood as well as for other concerns? How does non-engagement impact on understanding of threshold/safeguarding risk? Do we understand the risk when it is not sited in the home? (exploitation) In some areas the notion of consent could benefit from further work- for	

impact on delay of referrals being made; Impact of GDPR Tools can be restrictive Gap with ASD Review of consent	

KLOE 2: What is the quality of information sharing, both within, and between, relevant multi-agency meetings?

Standard 5; All relevant partners are identifies in a timely way, involved in cases and are appropriately engaged.

Standard 6; The practitioner demonstrates that they are aware of, understand, and apply information sharing protocols.

Standard 7; For the relevant multi-agency meetings the practitioner reviews the evidence, prepares reports (using the relevant template) and actively contributes to meetings.

Standard 8; There is evidence that a record of the meeting has been kept, with relevant actions, and that these have been communicated to partners, and families where appropriate.

<table>
<tr>
<td>What are we doing well?
When it’s good, it’s very good
TAF
Really important
How well Solihull shares information
Operational / Strategic meetings</td>
<td rowspan="2">What needs to happen?
Prioritising actions
Securing the plan- clear goals, jargon free
Ensure minutes are shared re core group/ CIN
Ability to share info effectively i.e. consent
Ensure all professionals involved form the beginning
Ensure clear procedures around all multi-agency meetings; YOS?
Ensuring levels of consent- informed consent/ override consent
Reassure parents about what will be shared and why- transparency
Accountability & escalation
Better cross boarder working
Use dispute resolution if key information is not being shared</td>
</tr>
<tr>
<td>What are we worried about?
Inconsistent – minutes/ invites
Assessment sharing
Front door- early help
Lack of child’s voice- early help
Reliance on drug screening
Don’t recognise contextual safeguarding i.e. vulnerable young males- criminal exploitation
Consent – levels of understanding
Not everyone understands info sharing and consent
Preconceptions about info sharing
Lack of understanding about info sharing in departments
Personal relationships and not</td>
</tr>
</table>

organisational relationships to share information Time constraints Professionals not using protocols DA good practice guidelines- especially in case conference	

KLOE 3 Is it evident that the voice of the child has been heard?

Standard 9; There is evidence to show that the practitioner has considered what life is like for the child
Standard 10; There is evidence of the child's wishes and feelings being gathered and considered in an age appropriate way
Standard 11; Diversity and disability issues are appropriately identified, understood , addressed and recorded.
Standard 12; Practitioners are able to articulate how the voice of the child has shaped their intervention

What are we doing well?	**What needs to happen?**
Good awareness Depending on age- pre-birth- teens Good verbal understanding Evidence of direct work Use of signs of safety Tools- GCP2 Ensuring wider issues- diversity Range of methods to get the voice of the child heard- age appropriate CAMHS feedback LACES team capture voice in PEPs Use of advocacy- NYAS Children being seen alone	Ensuring recording of child's voice in assessment/ referrals Being creative about how child's voice sought Ensure training is up to date Ensure meeting needs In safeguarding supervision question- what would the child say, how would the child experience this? Incorporate voice of parents/child in audits/ JTAI Service specific focus groups Consistent use of signs of safety in multi-agency work Assessment of hard to reach young people – be creative – not being distracted by own thoughts when listening When having a large siblings group ensure that all young people have equal opportunity to share their views Use interpreters when required If we can't see the child on their own should document why- there may be a good reason for this
What are we worried about? Childs experience not being passed across when they transfer provision Implementation in written form/ assessments not always evident This can be difficult for agencies not directly involved with children Experiences understood but not shaping plans explicitly Diversity-not explicitly understood- no one is weirder than your own family, each family has its own culture & this impacts on identity Not using child's voice to shape the service Ethical issues Not understanding the life of the child Adult mental health feedback Missed opportunity- i.e. not thinking outside of the box Not recording the voice of the child	

Which meetings should children be involved in and how can we facilitate this.	

KLOE 4: Are interventions working effectively to improve outcomes for the child/ren?

Standard 13; Intervention plans are in line with SMART principles, including a contingency plan which practitioners know when to use
Standard 14; Where there are complex needs/multiple plans in place, professionals are aware of their roles and responsibilities.
Standard 15; Interventions are continually assessed and these are having a positive impact on the child
Standard 16; Where appropriate, evidence based tools are used to inform continual assessment of interventions. For example, Graded Care Profile 2 and Signs of Safety.
Standard 17; Where interventions are not working or deterioration is recognised, action is taken to address this
Standard 18; Parental non-compliance and/or disguised compliance is recognised and acted upon appropriately. Parental assertions are checked and tested against other sources of information

What are we doing well?	**What needs to happen?**
Multi-agency forums e.g. TAF, core groups Good understanding of ACE's Stat timeframes and local policies mean action is taken in a timely way Learning from case reviews Increase of evidence based tools, signs of safety , GCP2, Barnardo's DVRIM Some processes more readily lend to assurance about regular review and update of the plan, some include clear views of the child re impact.	Training re ACE's in practice, not just identification, but also how to engage. Strengthen joint working with YOS More support re difficult families- strategies, approaches. Co-ordination and sequencing of interventions (high risk complex cases escalation) Are interventions early enough Communication about management of change Opportunities for collaboration Focus on wider exploitation not just CSE Emphasis on collaborative working and information sharing between agencies Ensure awareness of issues- i.e. criminal exploitation
What are we worried about?	
Use of GCP2 needs further embedding Plans not SMART so how can we effectively review? Parental disguised compliance isn't immediately obvious, at odds with value base Parental problems get in the way of timely change – what is a reasonable ask? ACE's how to intervene? Working with difficult to engage and chaotic families Top heavy interventions/	Can the audit process produce case specific comparison from agency audits comparing views about the extent of SMART plans? Wider sharing of NRM process and of duty arising- ensuring a valued approach when responding to call outs for young people (up to and beyond 18) Improved triangulation of evidence to check out parental and young person's assertions Look at learning styles of staff, parents

overwhelming families Thresholds changed over the years? Structural changes of support Impact of NRM and how this transfers to trigger plans Resources/ time Caseload volumes Evidence not reflected in notes	and multi-agency professionals Use of outcome star for TAF to screen/ monitor/ review

KLOE 5: Is supervision/management support used to aid reflective practice and to provide challenge to make a positive difference for the child?

Standard 19; The child is central to all decision making activity within the supervision process
Standard 20; The frequency of supervision sessions meets LSCB standards (minimum every 3 months), own agency standards and maybe more frequent commensurate with risk where appropriate
Standard 21; Practitioners experience supervision as providing an opportunity to reflect, to receive professional challenge and to be supported in providing challenge to others
Standard 22; The supervision process evidences management activity that is focused on ensuring practice is competent and compliant with local expectations and requirements

What are we doing well?	**What needs to happen?**
Strong sense that there are case supervision processes in place Recognising importance of supervision Action planning in supervision Flexibility to meet practitioners needs Weekly MDT meeting addressing safeguarding concerns and group supervision.	Recognition that supervision is different within each organisation, what are the benefits each agency can draw from this? Baseline expectations of supervision- negotiated with supervisee Consistent training of supervisors Practitioners to prepare for supervision to help streamline process time Post supervision action plan Share agency supervision policy with others if asked; particularly useful if developing or reviewing existing procedures Case learning meetings for ground level practitioners to discuss team difficulties, perspectives and share practice – group supervision TAF should be in place to form the facilitation for the family and then form the basis for supervision Group supervision for all agencies
What are we worried about? Is supervision reflective enough to support children young people and families? Management supervision styles Inconsistent supervision between agencies Time constraints resources Is time for supervision prioritised and protected well enough?	

On occasions decision son cases can be resource led- therefore supervision is useful to reflect on direction of travel and review existing action plans. Capacity/ motivation to change assessment Focus on template rather than the child	

KLOE 6: Are practitioners resolving professional disputes/disagreements in line with the dispute resolution procedure?

Standard 23; Practitioners are aware of the dispute resolution procedure and are able to locate it.
Standard 24; Where an issue has arisen, it has been resolved in line with the LSCB dispute resolution procedure.

What are we doing well?	**What needs to happen?**
Agencies aware of how to escalate Most issues do get resolved before the formal process Helps give a format to follow to address a need	Promote use/ access to the tool; e.g. training dry run Use template to promote clear thinking Use supervision to ask about challenge at informal stage that have not reached agreement Use and share some examples of challenge that have gone through the dispute resolution process- helps practitioners to visualise the process Case learning meetings could provide an opportunity to discuss some of these issues and reach a resolution in practice How do we count/ quantify the use of the process? We need to use the process and record evidence Need some way of resolving feelings Recognise that it is not always suitable for every situation
What are we worried about? Practitioners may not be aware of the actual dispute tool Time lag- missed opportunity Informal part of the process can be used but issue not resolved, the difference of opinion may still leave practitioner concerned. The risk that is not discussed with their own manager to consider the formal part of the process. Do practitioners understand that the process can be used in a variety of circumstances- not just re referrals? Wording of the policy / practice feels threatening- *does it? We disagree!* Previous experience of use was felt like the child was been let down- what was learnt from this? What is the point- with some agencies-	

response limited time Some people say they use it when they haven’t!! Where to find it	