Solihull Local Safeguarding Children Board

Multi-Agency Case Audit:

Overview Report

2015-2016

Executive Summary

This report will provide an overview of the findings of the 2015-2016 multi-agency case audit process.

In the 11 cases selected, the following areas of good practice were highlighted:

- Predominantly, the right agencies were involved in multi-agency meetings, who engaged and generally shared the relevant information. There is evidence that practitioners have knowledge of the information sharing protocols and applied these effectively.

- There were good referral processes in Solihull. Practitioners knew how to make a referral to the relevant agency and, where there was uncertainty around a referral, practitioners were confident in gaining advice.

- The threshold guidance was referenced and used to make appropriate referrals.

- There was generally good progress towards capturing the voice of the child from agencies, in particular Children's Social Work Services.

- Supervision occurred, with evidence of management oversight and support. The frequency of supervision followed LSCB guidelines.

The Case Audit also highlighted key areas of development to ensure that practice is continually improving. Table 1 illustrates these areas, the action already being taken to support these areas and the recommended next steps from the LSCB:

Table 1

Learning: 1. Improvements in record keeping and the logistics of child protection core groups and child in need meetings is needed	
Action Being Undertaken	**Next Steps from LSCB**
• The procedures in place for these meetings are currently being revised to make the process more robust and consistent. • A template has been developed for use in Child in Need meetings. This is awaiting approval from the Practice and Procedures Sub-Group. • The LSCB Practice and Procedures Sub-Groups have approved a template for use in Core Groups.	
Learning: 2. Timeliness and responsiveness of feedback from referrals to Children's Social Work Services needs improvement	
Action being Undertaken	**Next Steps from LSCB**
• The MASH is improving the timeliness and responsiveness of feedback from referrals. • Where referrals are sent through the online form, the referral and advice team send a copy of the referral along with the outcome feedback once MASH has made a decision on this. This can only be sent to a secure email address. • Where an agency does not have a secure email address, they are asked to contact MASH to discuss how these documents can be sent securely. • Outcome of referral known within two days of referral being made • MASH aim to have referrals managed with an outcome within 24 hours of it being received.	• Performance reporting to LSCB on MASH.

Learning: 3. Continued emphasis on raising awareness of the thresholds guidance and using this in practice is required	
Action being undertaken	**Next Steps from the LSCB**
• Representatives on the Case Audit Sub-Group are raising awareness of the thresholds guidance to practitioners in their agencies. • An external audit will be carried out on the understanding and application of thresholds in practice. This will be completed by February, with a formal report going to the LSCB in March. • The LSCB Communications Strategy to highlight importance of this guidance.	• LSCB representatives to continue to raise the awareness of the threshold guidance to practitioners in their agency.
Learning: 4. The position of agencies in gaining consent around referrals needs to be clarified	
Action being Undertaken	**Next Steps from the LSCB**
• The practice and procedures sub-group has identified further work to update protocols and this will include looking at the protocols around consent.	• Evaluate how consent is embedded in training and training strategy. • Evaluate training to ensure learning impact on practice.
Learning: 5. Further developmental work should be undertaken on consistently drawing out the voice of the child, in particular, where the child is too young/not engaging or where the practitioner mainly works with adults	
Action being Undertaken	**Next Steps from the LSCB**
• The LSCB has approved a recommendation to work with the Local Authority Engagement Strategy.	• Awareness raising of the importance of observations and young people. This is to be incorporated into training. • Direct practitioners to guidance that will help them overcome barriers of gaining the voice of the child via LSCB communications

Learning: 6. Continued awareness raising around interventions and disguised compliance is needed	
Action being Undertaken	**Next Steps from the LSCB**
• Serious Case Review 1 published and learning has been disseminated where this was a key element. • Core element in training packages and this is weighted appropriately.	• Continued communication from the LSCB around this. • Training evaluations and case audit process to evaluate how this is embedded in practice
Learning: 7. Formal supervision needs to be embedded in all agencies, in particular, in agencies where there is no formal process already in place	
Action being Undertaken	**Next Steps from the LSCB**
• LSCB guidance on supervision in place. • S11 audit and S175/157 are currently underway which will measure supervision within organisations. • The LSCB conference in November emphasised the importance of supervision. • Schools sub-group are reviewing arrangements around formal supervision	• Promote supervision standards developed in the case audit process and include in training.

Multi-Agency Case Audit

Introduction

Under section 14 of the Children Act 2004, LSCB's have a 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; and

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

This report relates to (b) and is about multi-agency case audit. Multi-agency case audit is one of the several strands that form the LSCB Learning and Improvement Framework. Performance data, section 11 audits, case reviews and training evaluation are also strands of this framework. These strands combine together to ensure that board members and agencies learn from experience and challenges to improve outcomes for children and young people. The framework promotes the culture of continuous learning and improvement across the LSCB.

This audit was undertaken by Case Audit Sub-Group of the Solihull Safeguarding Children Board. In April 2015, membership was revised, with a new chair who is the Head of Service for the Child Protection and Review Unit (CPRU) in the Local Authority. Membership was also increased to incorporate professionals from the CCG and Early Years and changes were made to the representatives of existing agencies.

The sub-group agreed and developed a new methodology for conducting case audits, building upon experience of working with previous models. It was agreed that the new model should be an annual programme, with the toolkit designed to offer clarity and be more accessible to practitioners. A twelve month programme was developed, and 10 key steps agreed to deliver single agency audit. Audit activity was concentrated during a three month period and the learning drawn together at an event designed to enable multi-agency analysis. The tool was designed to offer a more dynamic and interactive approach to carrying out case audits that had immediate resonance for partners and produced a viable end product to inform the LSCB on improvements required.

Cases were selected for the audit that focused on practice in the LSCB priority areas over a specified period time. These priority areas are;

- To support the delivery of Early Help services
- To promote practice on neglect
- To help children at risk of sexual exploitation

Cases were selected to support learning in relation to the following agreed key lines of enquiry, informed by recent serious case reviews;

- The quality and timeliness of information sharing across multi-agency meetings
- Professional understanding and knowledge of thresholds and referral processes
- Evidencing the voice of the child
- The effectiveness of interventions
- The timeliness and effectiveness of supervision/management support

Aims and Objectives of Case Audit

Aims

To contribute to the LSCB's statutory function to monitor the effectiveness of what is done by partner agencies for the purpose of safeguarding children and promoting their welfare in Solihull. The case audit aimed to establish the extent to which the LSCB is effective in supporting partnerships to continually improve practice in safeguarding children and promoting their welfare.

Objectives

At the end of the case audit programme for 2015-2016, the LSCB should have gathered information from the front line about children who are living with neglect and domestic violence, adult mental health problems and/or substance misuse, as well as children at risk of sexual exploitation and children receiving early help services. This information will be used to improve practice.

Methodology

Each partner conducted an audit and provided a presentation of their performance to a multi-agency audience. A total of 11 cases were audited, with 4 cases covering LSCB priority areas of Neglect, Child Sexual Exploitation and 3 cases covering Early Help. These were a snapshot of cases over a period of time.

Key lines of enquiry were agreed upon by the Case Audit Sub-Group and these were phrased as questions the LSCB should be asking about front line practice. They were influenced by learning from audits carried out in 2014-2015, national experience and local serious case reviews and practice. Standards of performance that might be expected against these lines of enquiry were also developed. Auditors were asked to review their cases against these standards. The use of key lines of enquiry and standards within these ensured the audit process retained a focus and was confined to LSCB priorities.

Audits were conducted by managers working in each of the agencies and 'auditors' were encouraged to include the practitioners who worked on the individual cases in the process. Agencies only had to audit cases that they had involvement in.

Findings

A summary of the findings of the case audit can be found on page 5.

Findings of the case audits were pulled together in a practitioner led learning event. In addition to completing detailed audits, each agency involved was required to prepare a presentation of their audit findings at the event. The presentations focused on the agencies perspective of the standards met, and the standards unmet and why in the audit. Findings were also presented on how agencies own work and partnership working could be improved. These presentations are summarised and collated in Appendix 2.

Following the presentations, partners were asked to analyse the findings in regards to the LSCB priorities. The strengths, areas of development and next steps for multi-agency work were considered. This aimed to provide a picture of practitioner's views of current multi-agency working in regards to the priorities.

Future Learning

There are limitations in the recording of the results from the audit. In some cases, some agencies replied 'not applicable' as a particular standard did not apply to the work of their agency. Where these responses were received, this information was not recorded therefore the data does not always reflect the total response to all standards from all agencies. What is more, where a standard was not relevant to the particular case, some agencies referred to other cases they have been involved in where they had a similar experience. These responses were not taken into account in the recording of the results as they did not apply to the audited cases.

In some cases, there was a tendency in presentations for agencies to focus on the performance of others rather than reflecting on their own practice. Future audit programmes should stress that the first phase of the audit should reflect agencies own practice and where issues have been identified with others performance, agencies should record what they did in their individual work to take these concerns forward.

Learning can be taken forward from the event. Although there was attendance from a spread of agencies, a wider cohort of practitioners and managers attending would enrich the debate, inform the analysis, and ensure key learning is disseminated further. The event was half a day, more could be achieved if this were extended to a whole day.

Methodology: Next Steps

- To continue with the new methodology for case audits.
- Future case audits should highlight that where concerns have been identified with other agencies, ‘auditors’ should reflect on how these concerns were taken forward in their own work
- Devise standards that limit the possibility of giving ‘non applicable’ as an answer.
- A wider audience to be invited to the subsequent learning event to further inform the analysis.
- Dedicate a day, rather than half a day, to the learning event in order to consolidate learning.

Summary of Findings

KLOE 1: What is the quality and timeliness of information sharing including core group work, MASE, early help and other appropriate multi-agency meetings?

Across all cases that were audited, practitioners demonstrated that there were areas of good practice in regards to the quality and timeliness of information sharing. In 85% of cases (9 out of 11 cases), it was reported there were the right agencies involved and, in 68% of cases (7 out of 11 cases), relevant partners engaged and shared the appropriate information. In all 11 audited cases, the practitioners involved demonstrated that they had knowledge of information sharing protocols and that these were applied effectively.

Logistics of multi-agency meetings were challenging. The audit highlighted that Housing and Early Years were not always invited to attend these meetings as there can be a lack of awareness as to their involvement and the important contribution they have to make. In the three cases Housing had involvement in, Housing were not invited to multi-agency meetings in two out of the three cases. In the one case audited by Early Years, they too had no involvement and were not informed of the proceedings around the child. Similarly, in four out of the five cases audited by the CCG, GP practices did not play a part in the multi-agency planning.

Agencies recorded that the distribution of minutes and records of minutes from Child Protection Core Group and Child in Need meetings were not always timely in the cases audited, with some agencies reporting that in three separate cases, they did not receive the relevant records. It was also identified that in some agencies key information is not always shared with relevant practitioners. This was evidenced in a CSE case audited by the CCG as the GP involved was not aware that there was a CSE concern around the child. Likewise, in an Early Help case, the school nurse was not aware that the child was considered in a multi-agency forum or had received no documentation around this.

Children's Social Work Services (CSWS) acknowledged they held little information in one CSE case that was audited. CSWS noted this was because there was no identified worker to carry out CSE work. As a result of this, CSWS have commented that they will support workers increased learning around CSE.

KLOE 2: Do practitioners have the knowledge to apply correctly the thresholds and referral processes to support effective and accountable practice?

The audit demonstrated that there were good referral processes in Solihull, with all agencies across all 11 cases reporting that practitioners were aware of how to make appropriate referrals to relevant agencies. Where there was uncertainty around a referral, all agencies noted that practitioners knew where to go for advice.

Issues were identified with receiving feedback after a referral was made; in 29% of cases (3 out of 11 cases), no feedback was received. Yet, there can be confidence

that when feedback had not been received, practitioners took action to pursue this; in 80% of cases (9 out of 11 cases), agencies recorded that they followed up feedback from a referral.

There was uncertainty amongst certain agencies about obtaining consent around a referral, in particular from the Police and the Voluntary Sector. In seven out of nine cases audited by the Police, no evidence was provided of the practitioner obtaining consent and consequently this is not captured in Police records. The Police identified there was a lack of clarity about the procedures around gaining consent. Similarly, the Voluntary Sector reported the same concern.

There was evidence in 78% of audited cases (8 out of 11 cases) that practitioners knew where to find the threshold guidance. Indeed, some practitioners could report that they kept printed versions of the guidance to have to hand in their offices. Where practitioners were aware of the guidance this was used in making referrals in 8 out of 11 cases.

However, whilst the use of thresholds is strongly rooted in the majority of agencies, Housing and the CCG acknowledged that the use of thresholds may not be embedded in the work of all their practitioners. In the three case audited by Housing, the practitioner did not know where to find the thresholds guidance and subsequently this could not be used in the referral process. The CCG also acknowledged that in four out of five cases audited, the thresholds guidance was not referenced. As a result of the audit, these agencies have now made a commitment to continue to raise the awareness of the guidance to ensure it is embedded in the work of their practitioners. What is more, the virtual involvement of Housing in the MASH team will further support their practitioners to reference thresholds.

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

There is generally evidence of good progress being made towards capturing the voice of the child in the cases audited. In particular, this was an area of good practice for Children's Social Work Services as it was recorded across all their audited cases that the voice of the child had been heard and considered.

In cases where agencies had not evidenced that the voice of the child was considered, there were identified challenges in gaining and documenting this. The following key issues were noted in four different cases included in the audit.

In one case, Education noted that the child did not engage with the service so therefore their voice could not be reflected in case files. Issues were also identified in two different cases by Education and HEFT around the age and ability of the child involved. Both agencies reported that the wishes and feelings of the child could not be gathered as the child in both cases was too young. Furthermore, in another case it was identified that where a practitioner's main remit is working with adults, there was a concern that the voice of the child was not reflected in case files as these were often 'adult focused.'

Evidencing the voice of the child was a particularly important area for the Police who across eight out of their nine audited cases had not gathered the voice of the child in their case files. There were identified issues around documenting this in an age appropriate and meaningful way.

In two cases, practitioners were not able to evidence the voice of the child. However, other agencies bought these to multi-agency meetings and in both cases, this was CSWS.

In 80% of cases (9 out of 11 cases), agencies reported that diversity and disability issues were addressed and recorded appropriately in case files.

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

In just over half of the cases (51%), there was evidence that interventions were continually assessed and were having a positive impact on the child. However, where interventions were not working, agencies were confident that this was recognised.

In 44% of cases (5 out of 11 cases), no evidence was provided that there was a contingency plan in place.

There were issues identified around interventions in the audited cases. A neglect case highlighted the following key issues. CSWS noted the potential for change was not identified for the parents and that when interventions were not working, the only action taken was advice. Furthermore, parental non-compliance/disguised compliance was not acted upon as the case drifted for too long. Both Education and SIAS also commented in the same case that interventions were not continually assessed due to meetings not taking place between agencies. CSWS continue to place an emphasis on greater consideration of disguised/non-compliance and analysing the potential for change in parents. In addition to this, the relevant manager is aware of the issues raised in the case and is working to address the gaps in practice.

Concerns arose around interventions in regards to CSE in particular cases. CSWS identified that the social worker on one case had not received any training on CSE. In another case no CSE worker was identified and this was also a concern noted by Education in the same case.

In eight out of the nine cases audited by the Police, there was no evidence that interventions were assessed or that action was taken to address issues when they were not working. This is due to the assumption within the agency that there were already interventions in place on a case and that these were having a positive impact.

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

There was evidence of good practice in terms of supervision in the cases audited. Overall, in 73% of cases (8 out of 11 cases) agencies demonstrated that the child was central to all decision making activity within the supervision process. However, the Police reported that the child was not central in supervision in four of their audited cases. The Police have identified that improvements need to be made in capturing and documenting the voice of the child in their records. Furthermore, in 80% of cases (9 out of 11 cases), agencies reported that the supervision process evidenced management oversight and support that assesses practitioner's compliance and professional confidence.

Agencies commented that in 73% of cases (8 out of 11 cases) supervision regularly took place and was in line with LSCB guidance, however, the frequency of supervision varied within some agencies. Education noted that supervision did not occur in every audited case. This is due to task management being varied within schools therefore there is no formal supervision process in place. The Voluntary Sector also identified that there was no formal supervision. HEFT reported that there are supervision policies, but it did not take place in half of the cases they audited. However, in these cases, this was down to inescapable factors such as long term sick leave and changes in staffing.

Opportunity for reflection and challenge in supervision was demonstrated within the audited cases. In three out of the eight cases audited by CSWS, however, practitioners reported that they wanted more opportunity for reflection within supervision.

The Learning Event

The development of the learning event was a key change to the case audit methodology. The event bought together a multi-agency forum made up of auditors and practitioners involved to analyse the performance of the LSCB. In total, 22 practitioners across 10 agencies attended the event. Table 2 provides a breakdown of this attendance by agency.

Table 2

Agency	Attendance
Solihull CCG	2
HEFT	1
Community Rehabilitation Company	1
Early Years	1
Schools	1
SMBC Children's Services	1
SMBC	5
SIAS	2
Solihull Community Housing	3
Voluntary	1
West Midlands Police	4

The event aimed to pull together findings from the case audit, giving each agency the opportunity to present their findings from their perspective. Agencies prepared and delivered presentations on the standards met, the standards unmet and why and how their own work and partnership working could be improved. These presentations gave practitioners the opportunity to not only share their work, but successfully engage with one another's performance.

Practitioners who attended the event also participated in group work that analysed the overall multi-agency performance in relation to the LSCB priorities. Practitioners were asked to consider the strengths, areas for development and next steps in regards to the LSCB priorities based on the audit findings. This group work was effective in gaining the perspective of practitioners on current multi-agency working. Table 3 outlines the findings from this work.

Table 3

Learning Event – Group Work

	Strengths	Areas for Development	Next Steps
Early Help	• When up and running will pull services together – interventions earlier and at a lower level. Practitioners understand when CYP need additional support. • Help at the point of need and assessment • Practitioners pro-active, liaising well, referring appropriately with a focus on the child, pulling everything together. • Appears less 'threatening' to families than CSWS involvement • Embedded values and philosophy	• Thresholds – what happens when a referral is made? • Engagement journey • Cascading of information as to how early help will look and what they can offer • Development of Early Help website immediately • Ensuring key agency involvement (Early Help Map/MASH previous key agencies not involved) • Clarity of roles • Who is minute taker?	• Clarity of referral process • Advice re: Thresholds and where to refer to (How do we refer to Early Help?) • Communication so Early Help role is understood • Understanding of what Early Help means, who is involved and terminology used • Sharing of information from agencies – how this is done to prevent/try and address escalation of concerns • Changes to CAF process • Thrive Model and 9 impact factors
Neglect	• Graded Care Indicators • For those agencies who recognise 'impact' on child – child's voice heard • Practitioners able to make appropriate referrals • Chronology of events recorded by professionals to support neglect cases (not all agencies) • Updated policy and toolkits	• Multi-agency training around indicators of neglect • Responsiveness to referrals • Some agencies (Police) to look at information in a chronological way rather than focusing on individual incidents • Practical understanding of neglect • Who is minute taker?	• Raising awareness of the tools e.g. indicators for graded care • Improve the dialogue between the referrer and the referral team • Raising awareness of Threshold Document to embed • Align with neighbouring models • Thrive model and 9 impact factor

CSE	• Commitment people have to addressing CSE • Clearer definition • Lots of practitioner training – spotlight on CSE – focus on screening tool • Police CSE team – CMOG/MASE established • Dedicated CSE workers in Early Help • Heightened awareness • Willingness to engage	• Evaluation of impact • Parental focus on what to look out for in regards to CSE • Victims/children training to recognise CSE • Who is minute taker? • Levels and thresholds are inconsistent	• Shared understanding of the screening tools • Work on a fully functioning LSCB website • Promoting positive examples • Parental, Victim, Peer CSE education • Threshold and CSE screening tool need consistency • Thrive model and 9 impact factors

Conclusion and Recommendations

Overall, the case audit was successful in highlighting both areas of good practice and areas of development to ensure that there are effective safeguarding practices in Solihull. In order to determine what these areas looked like, a new methodology was developed which focused on the LSCB priorities. This methodology provided a positive change to the case audit process as detailed audits were completed along with presentations on the audit findings. This methodology ensured there was focus within the case audits and analysis and debate around the findings.

The case audit reinforced the good practice of practitioners in Solihull. Predominantly, in the cases audited, multi-agency meetings involved the right agencies who engaged in the process and generally shared the relevant information. Practitioners were aware of the information sharing protocols and applied these effectively within their work. There was evidence of good referral processes in Solihull, with all practitioners across the audit reporting that they knew the referral procedure and were able to gain advice around a referral. There was confidence that where feedback had not been received following a referral, practitioners took action to pursue this. What is more, there was knowledge of the thresholds guidance and this was referenced in making referrals. There was good progress in capturing the voice of the child and considering the child's wishes and feelings. Furthermore, supervision occurred that was in line with LSCB guidelines.

The case audit process ensures the effectiveness of what is done by each agency and guarantees that there is a culture of continuous learning across the board. As a result of this, areas of development for the LSCB were highlighted in the audit findings. Action is already being taken in some of these areas whilst other areas require further action from the LSCB. The recommendations from the case audit process will inform the LSCB improvement plan.

<u>Key Area of Development 1</u>

It was identified that the logistics around multi-agency meetings can be challenging, in particular Child Protection Core Groups and Child in Need meetings. Agencies such as Housing and Early Years are not always involved in these meetings and there is sometimes a delay in the distribution of records and minutes from these meetings.

What action is being undertaken?

- The procedures in place around these meetings are currently being reviewed in order to make processes for these meetings more robust and consistent.
- Templates for both Core Group and Child in Need meetings have been developed. These templates will support social workers to keep a record of these meetings.

<u>Key Area of Development 2</u>

Feedback from referrals to Children's Social Work Services was not always timely, with it reported in some cases that feedback was not received at all.

What action is being undertaken?

- The MASH is now established which is improving the timeliness and responsiveness of feedback to referrals. The referral and advice team ensure that a response is received as the

referrer will receive a copy of their referral along with the outcome feedback once MASH has made a decision on this, via their secure email within two days of the referral being made.

LSCB Next Steps

- Performance information on MASH should be reported to the LSCB so the timeliness and responsiveness of feedback to referrals can be monitored.

Key Area of Development 3

There needs to be continued emphasis on raising the awareness of the thresholds guidance and how this is used in practice.

What action is being undertaken?

- Representatives on the Case-Audit Sub-Group are continuing to raise the awareness of the guidance to their practitioners and are encouraging its use in practice.
- An external audit will be carried out on the understanding and application of thresholds in practice. This will be completed by February, with a formal report going to the LSCB in March.
- The LSCB has highlighted the thresholds guidance as a key document to be promoted in its 2016-2017 Communications Strategy.

LSCB Next Steps

- LSCB representatives to continue to raise awareness of the guidance within their agencies

Key Area of Development 4

There is uncertainty amongst specific agencies on the procedures around obtaining consent for a referral. These procedures need to be clarified and made accessible to practitioners.

What action is being undertaken?

- The Practice and Procedures sub-group has identified further work to review LSCB procedures and this will include considering the procedures around consent and how accessible these are to practitioners.

LSCB Next Steps

- Evaluate how consent is embedded in training and the training strategy and use training evaluations to ensure impact of learning on practice.

Key Area of Development 5

Work can be undertaken on consistently drawing out the voice of the child, particularly, where the child is too young, not engaging or where the practitioners main remit is working with adults.

What action is being undertaken?

- LSCB have agreed action to work with the Local Authority Engagement Strategy.

LSCB Next Steps

- Awareness raising of the importance of observations for younger children and this to be incorporated in training.
- Direct practitioners to guidance and research that will help them overcome the barriers to gaining the voice of the child via LSCB communications.

Key Area of Development 6

There needs to be continued work around interventions and the impact that these are having, especially in terms of neglect cases.

What action is currently being undertaken?

- Serious Case Review 1 has been published and learning has been disseminated where this was a core theme.
- Work on interventions is a core element in training packages and is weighted appropriately.

LSCB Next Steps

- LSCB to continue communication around the importance of interventions and assessments.

Key Area of Development 7

It was acknowledged that not all agencies carry out formal supervision sessions. All agencies should carry out formal supervision; in particular, those were there is no formal process embedded.

What action is being undertaken?

- There is LSCB guidance on supervision in place.
- S11 audit and S175/157 audits are currently in progress which will measure supervision within organisations
- LSCB conference highlighted the importance of supervision to managers and supervisors.
- Schools Sub-Group are reviewing arrangements around formal supervision within schools.

LSCB Next Steps

- Disseminate LSCB guidelines on supervision developed in case audit process.

Single Agency Learning

The case audit process also identified areas of development within agencies own practice. This has been broken down into an action plan which will also form part of the LSCB's improvement plan. This will be monitored to ensure that actions are carried out. The single agency action plan can be found in Appendix 3.

Appendices

Appendix 1 - Case Audit Toolkit

Local Safeguarding Children Board

Case Audit toolkit

INTRODUCTION:

The statutory objectives and functions of LSCBs are set out in section 14 of the Children Act 2004 and are to:

(a) Coordinate 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; and

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

This document relates to (b).

The LSCB learning and improvement strategy is made up of several strands which combine to deliver the LSCB role in monitoring effectiveness. These strands include performance monitoring, case reviews, training evaluation, section 11's and learning from case audit.

The LSCB requires a bespoke toolkit which will provide sufficient rigour, is efficient and has demonstrable learning to impact on practice. This (draft) toolkit aims to provide a structure to carry out multi-agency case audit, but with enough flexibility to apply the LSCB's annual changing priorities year on year. The kit explains the principles of carrying out case audit. This is followed by scope and definition, aims and objectives and a summary of the process. A description of how each step is approached is provided and finally the use of the LSCB learning log and impact on practice.

This toolkit is the first and will be a pilot in year 2015-2016 and will continually improve using local and national experience.

Ten steps to improve impact through case audit; A one year programme

Step one;

Create a model together

Step two;

Agreed the overall design

Step three

Agree on case selection criteria

Step four

Agree the Key lines of enquiry

Step five

Agree standards

Step six

Test the toolkit

Step seven

Carry out single agency audits

Step eight

Carry out multi-agency analysis

Step nine

Report to LSCB

Step ten

Deliver on impact via the learning log.

This is a one year cycle and aims to provide information from practice to inform the LSCB strategic priorities and planning.

Scope and definition

Multi agency case audit tells us about what is happening in practice in relation to the LSCB priorities for 2015/2016 which are;

- To help children at risk of sexual exploitation
- To promote positive practice on neglect
- To support the delivery of Early Help Services.

Case audit is confined to the examination of a number of cases using agreed selection criteria and standards, Emerging issues, such as operational imperatives or the need for further review of an individual case, will be referred appropriately.

Case audit is not the same as case review. Case review is an in-depth enquiry into an individual case. Case audit is the examination of a number of cases to consider whether we are meeting our own agreed standards and key lines of enquiry.

Key lines of enquiry (KLOE) are the questions the LSCB wants to find out about practice.

Standards are what we expect or hope to find when we ask those questions.

Principles of case audit.

The toolkit is applied using the following principles;

- Front line professionals will be involved throughout the process.
- Agency representatives will be auditors of their own cases and will agree on the standards set and consult with practitioners in advance of the audit.

- Case file sharing will not be necessary.
- Where appropriate, the child views will be used to inform the audit.
- Information is shared using LSCB information sharing protocols and processes. Information is shared in order to carry out a core function of the LSCB.
- For economy and efficiency, time will be committed by each partner on preparation, attending an event and contributing to the final report.
- Dates for the event and meetings will be set one year in advance.
- Partners involved must assign a suitable deputy, who is well briefed on the process to provide cover in the event of urgent leave.

Case audit Aim

Case audit is a component of the LSCB's statutory function to monitor the effectiveness of what is done by partner agencies for the purpose of safeguarding children and promoting their welfare in our area.

Case audit will establish the extent to which the LSCB is effective in supporting partnerships to continually improve practice in safeguarding children and promoting their welfare in a small cohort of cases.

Objectives

At the end of the case audit programme for 2015-2016, the LSCB will have established information about practice in relation to children;

- living with neglect and domestic violence, adult mental health problems and or substance misuse.
- at risk of sexual exploitation
- receiving early help services.

Case selection

The numbers of cases selected will be decided by the case audit group and will depend on capacity issues and logistics management. (A minimum of 12 cases, 4 children experiencing each of the above features will provide a sample of practice experience.)

The local authority will lead on case selection, because they have access to the majority of the children this group will identify.

Key lines of enquiry;

The key lines of enquiry will have been agreed by the case audit group and are consistent with the LSCB core function and form the framework for the audit. They are influenced by learning from audits carried out in 2014-2015 and national experience. They are phrased as questions the LSCB should be asking about frontline practice.

KLOE 1: What is the quality and timeliness of information sharing including core group work, MASE, early help and other appropriate multi-agency meetings?

KLOE 2: Do practitioners have the knowledge to apply correctly the thresholds and referral processes to support effective and accountable practice?

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

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

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

Using these as lines of enquiry the following standards should be used to audit cases.

STANDARDS FOR CASE AUDIT

Introduction
This is a set of standards for use by the partners in carrying out case audit. These standards will be important as they will ensure the audit process retains a focus and is confined to the LSCB key priorities. Auditors will be asked to review their files against these standards. Any additional learning arising from the audits will be referred for further work.

The setting of standards provides a number of advantages;

- It provokes discussion on what is realistically achievable.
- It helps as a reminder of the standards we aspire to.
- It engages professionals in the intellectual debate

KLOE 1: What is the quality and timeliness of information sharing including core group work, MASE, early help and other appropriate multi-agency meetings?

Standard 1: The right agencies are involved

Standard 2: All relevant partners (e.g. substance misuse services, mental health services, learning difficulties) are appropriately engaged, share appropriate information and contribute to the relevant multi-agency meetings(e.g. core groups, MASE, early help, child protection conference)

Standard 3: The professional demonstrates that they can apply information sharing protocols.

Standard 4: Relevant multi-agency meetings (e.g Core Groups, MASE, early help meetings and child protection conferences);

- Are arranged and held in a timely manner
- Are attended by all relevant partners
- Are recorded and the record is shared in a timely manner with attendees, with actions assigned accordingly.
- The practitioner reads the record of the meeting, reviews them and takes appropriate action e.g. making amendments.
- Case recording complies with standards set by the organisation and evidences that the welfare of the child is considered.

KLOE 2: Do practitioners have the knowledge to apply correctly the thresholds and referral processes to support effective and accountable practice?

Standard 5 The practitioner knows where to find the thresholds guidance

Standard 6 The practitioner is aware of how to make appropriate referrals to all relevant agencies, including safeguarding referrals and out of hours services.

Standard 7 The practitioner is clear about obtaining consent.

Standard 8 Where referrals have been made, feedback has been received.

Standard 9 Where feedback has not been received; the practitioner has taken action to pursue this.

Standard 10 The practitioner uses the threshold guidance to support high quality, evidence based referrals.

Standard 11 The practitioner is aware of where to go for advice if he/she needs clarification.

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

Standard 12 There is evidence to show that the practitioner has considered what life is like for this child.

Standard 13: There is evidence of the child's wishes and feelings being gathered and considered in an age appropriate way

Standard 14 Diversity and disability issues are appropriately identified, understood, addressed and recorded.

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

Standard 15 Interventions are continually assessed and are having a positive impact on the child.

Standard 16 Where interventions are not working or deterioration is recognised, action is being taken to address this.

Standard 17 Where relevant, parental non-compliance and/or disguised compliance is recognised and acted upon appropriately

Standard 18 A contingency plan is in place, the practitioners understands when this should be applied.

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. 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 Supervision process evidences management oversight and support that assesses practitioners compliance, and, professional competence/confidence with regard to adhering to local policies, protocols and procedures, and promotes timely progression of the case.

Single agency audit: Name of case to audited:		
Key Line of enquiry (1) What is the quality and timeliness of information sharing including core group work? Please provide evidence to demonstrate the completed sections.		
Standard	**Met or exceeded**	**Not met and why**
Standard 1: The right agencies involved		
Standard 2: All relevant partners (e.g. substance misuse services, mental health services, learning difficulties) were appropriately engaged, shared appropriate information and contributed to the relevant multi-agency meetings(e.g. core groups, MASE, early help, child protection conference		
Standard 3: The professional demonstrates that they can apply information sharing protocols.		
Standard 4: Relevant multi-agency meetings (e.g Core Groups, MASE, early help meetings and child protection conferences); • Are arranged and held in a timely manner		

• Are attended by all relevant partners • Are recorded and the record is shared in a timely manner with attendees, with actions assigned accordingly. • The practitioner reads the record of the meeting, reviews them and takes appropriate action e.g. making amendments. • Case recording complies with standards set by the organisation and evidences that the welfare of the child is considered. .		

Single agency audit: Name of case to audited:		
KLOE 2: Do practitioners have the knowledge to apply correctly the thresholds and referral processes to support effective and accountable practice? Please provide evidence to demonstrate the completed sections.		
Standard (The practitioner has evidenced) :	**Met or Exceeded**	**Not met and why**
Standard 5 The practitioner knows where to find the thresholds guidance		
Standard 6 The practitioner is aware of how to make appropriate referrals to all relevant agencies, including safeguarding referrals and out of hours services.		
Standard 7 The practitioner is clear about obtaining consent		
Standard 8 Where referrals have been made, feedback has been received.		
Standard 9 Where feedback has not been received; the practitioner has taken action to pursue this		
Standard 10 The practitioner uses the		

threshold guidance to support high quality, evidence based referrals.		
Standard 11 The practitioner is aware of where to go for advice if he/she needs clarification.		

Single agency audit: Name of case to audited:		
KLOE 3 Is it evident that the voice of the child has been heard? Please provide evidence to demonstrate the completed sections.		
Standard	**Standard Met/Exceeded**	**Standard not met and why**
Standard 12 There is evidence to show that the practitioner has considered what life is like for this child.		
Standard 13: There is evidence of the child's wishes and feelings being gathered and considered in an age appropriate way		
Standard 14 Diversity and disability issues are appropriately identified, understood, addressed and recorded.		

Single agency audit: Name of case to audited:		
KLOE 4: Are the risks to children reducing as a result of interventions? Please provide evidence to demonstrate the completed sections.		
Standard	**Standard Met/Exceeded**	**Standard not met and why**
Standard 15 Interventions are continually assessed and are having a positive impact on the child.		
Standard 16 Where interventions are not working or deterioration is recognised, action is being taken to address this.		
Standard 17 Where relevant, parental non-compliance and/or disguised compliance is recognised and acted upon appropriately		
Standard 18 A contingency plan is in place, the practitioners understands when this should be applied		

Single agency audit: Name of case to audited:		
KLOE 5: Is supervision/management support used to aid reflective practice, to provide challenge and make a positive difference for the child? **Please provide evidence to demonstrate the completed sections.**		
Standard	**Standard Met/Exceeded**	**Standard not met and why**
Standard 19 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 Supervision process evidences management oversight and support that assesses practitioners compliance, and, professional competence/confidence with regard to adhering to local policies, protocols and procedures, and promotes timely progression of the case		

Guidance for auditors

Introduction

This is a guide for auditors to clarify their contributions to the case audit programme.

The aim of the case audit programme is to establish the extent to which the LSCB is effective in supporting partnerships to continually improve practice in safeguarding children and promoting their welfare.

Using the key lines of enquiry auditors will assess whether the standards were met or not supplying evidence and explaining why.

The audit will focus around those standards and a framework table has been included in this toolkit.

The case audit process

Working with practitioners, you will carry out the audit process in relation to individual children and present your collated findings to a multi-agency group made up of auditors in partner agencies.

The steps to follow are described below:

Upon receipt of the list of names, you will carry out a search in your agency to identify what professionals have been working with the child. You may find that you have had no involvement in some cases. If this happens, then please inform the LSCB manager and carry on with the children that are known to your agency.

You will then contact the professional and provide them with a briefing on the audit process, including the date for the audit event.

You will then send the audit toolkit to the professional(s) concerned, providing them with support and advice as necessary.

You then arrange a meeting with the professional(s) and review the files with them and complete the framework provided *together.*

Now you must prepare a presentation on the power point provided for the event on your collated findings.

You are asked to provide a summary of the standards which were met or exceeded, those unmet and why, areas for improvement in your organisation, and your suggestions to how the multi-agency system might be improved

Professionals will be invited to the event. They should be reassured that their individual case will not be presented, but the audits may be used as reference for discussion and analysis throughout the event.

At the event, you and other partners will make similar presentations from their individual agency perspective on their collated findings.

These findings will then be the focus of a multi-agency group analysis and discussion which will focus on the effectiveness of the LSCB, In relation to partnership working, the analysis will focus on areas of strength, weaknesses and why they occur, followed by a summary of lessons learned and next steps.

(Two and a half hours) E*vent: Multi-agency Case Audit*

Attendance by managers / safeguarding leads and practitioners

Event aim:

To establish lessons learnt from case audits by evaluating the impact of multi-agency collaboration on the lives of the children selected.

Event objectives;

The event will produce;

- An analysis of findings of audits and implications for partnership working.
- A list of lessons learned.

Programme

Introductions, welcome, structure and purpose of the day- Case audit group chair.

Foreword: LSCB chair

Presentations: Health, police, local authority, school(s), children's centres and any other involved agency present collated findings. (power point template provided)

Fact checking and summing up

Small group work: Assessing the LSCB effectiveness

Large group discussion: What are we doing well and what do we need to do better?

Next steps

Writing up the event

Audits carried out by individual agencies will be used as reference to inform the report, in the same way they were used to inform the discussion at the event. The power point presentations will be similarly used as reference. Also, the group analysis will come up with a list of lessons learned.

The report to the LSCB will have the following headings;

- Introduction: What this report is about.
- Methodology: How the case audits were carried out
- The event: A summary of the event. A full record will be included as an appendix
- Using the lines of enquiry as headings, a summary account of the findings.
- Analysis: This will use the group analysis from the event
- Conclusions: A narrative on what was learned from practice, comments on methodology.
- Lessons learned: A list of lessons learned to be addressed by the LSCB directly and placed in the learning log.

All documentation will be kept in the LSCB folder.

Next steps and lessons learned

The LSCB maintains a learning log. This is a repository of information gleaned from case audits and is used to ensure the LSCB uses this information to improve practice.

Lessons learned from case audits will be added to the learning log.

They will be used to inform training, policy, communications and priority setting or any other function of the LSCB.

This will be a permanent case audit cycle, changing in line with the LSCB priorities and needs.

Appendix 2

Summary of Findings from Presentations				
Agency	**Standards Met**	**Standards Not Met and Why**	**Improvements to be Made**	**Improvement to Partnership Working**
CCG	***Quality and Timeliness of information sharing*** It is demonstrated that information is shared effectively. There is a relevant storage of information and flagging of this. ***Awareness of thresholds and referral processes*** One GP practice was familiar with the threshold document. Demonstrated that practitioners refer appropriately and are followed up when no feedback has been received. It is also clear where to go for advice regarding referrals. ***The voice of the child*** There is evidence that the voice of the child is listened to.	***Awareness of thresholds and referral processes*** There was a lack of awareness in two cases of the thresholds guidance. Lack of knowledge of the concerns (CSE) in one of the cases. Request for information and feedback did not provide the detail.	Training to include the thresholds criteria in scenarios. Awareness raising of the thresholds criteria is taking place.	Consideration of requests/feedback to provide GP with detail around the safeguarding concern.
HEFT	***Quality and Timeliness of***	***Awareness of thresholds***	Heighten the awareness	Joint communication

	information sharing Appropriate agencies involved, information sharing followed protocols and meetings were timely. ***Awareness of thresholds and referral processes*** Practitioners able to gain consent confidently and obtain advice around referrals. ***The voice of the child*** Diversity and disability issues addressed. ***Effectiveness of Interventions*** Evidence of on-going assessments and evaluation of interventions. ***Supervision*** Supervision taking place but not frequent	***and referral processes*** There is a general broad awareness of the thresholds document but this has not been embedded in practice. Practitioners had not made a referral or had not felt it was necessary to reference this as it had not been implicated in their practice. Feedback from CSC referrals was not timely. ***The voice of the child*** On occasions, practitioners not always talked directly to child to gain their wishes and feelings. Sometimes there was minimal contact with the child. Issues were also identified with engaging younger children.	and cement the use of the Thresholds document. Consider auditing the feedback process and raise concerns to partner agencies if indicated. Challenging practitioners and raising the profile of the voice of the child during CP and managerial supervision. Promote practitioner confidence around this.	methods. Regular updating for professionals of new policies, pathways and processes. Link professionals to disseminate information or to feed information/concerns into.
Police	***Quality and Timeliness of information sharing*** Information was shared and there is knowledge of the relevant protocols.	***Quality and Timeliness of information sharing*** Meeting attendance isn't always clear and issues around who should be	Engage and understand – better understanding of environment Predict and prevent-	High levels of awareness to generate information, intelligence, referrals and evidence

	Awareness of thresholds and referral processes There was is an application of the thresholds by the PPU staff. ***Supervision*** Supervision is taking place and there is appropriate case management.	invited. ***Awareness of thresholds and referral processes*** There is confusion around obtaining consent. The application of the thresholds document is not taught frontline staff and therefore is not embedded across the whole organisation. Dots are not being joined between impact factors. ***The voice of the child*** There is uncertainty of how to document the voice of the child. ***Effectiveness of Interventions*** Risks not reducing in the cases. There is an assumption that there are already interventions and that these are working. ***Supervision*** Child not central to all decision making in supervision. Improvement in how the voice of the child	reduction in demand/crime/offenders /first time entrants to the system/risk to the vulnerable Respond and resolve- improvement in response Evaluate and innovate – collaboration and learning	Flagging on all relevant IT systems Analytical or research capability to make sense of information Products generated to inform tasking Effective risk assessment and tasking processes Action – early intervention, disruption, enforcement

		will be captured in work.		
Children's Social Care	***Quality and Timeliness of information sharing*** Right agencies involved, information shared in a timely manner, CIN meetings well attended. ***Awareness of thresholds and referral processes*** Thresholds and referral processes understood and feedback gained Understanding of thresholds used in relation to CSE neglect. CSE screening tool used together by CS and multi-agency colleagues with liaison with CSE team. ***The voice of the child*** Evidence of engaging children in age appropriate way, with additional need s/disability taken into account in communication method, voice of the child evident and evidence of consideration of what life is like for the child.	***Quality and Timeliness of information sharing*** Withdrawing of service due to Early Help changes Information not shared between private organisations caring for a child on behalf of Solihull. Strategy discussion not held in timely manner Information sharing between internal CS teams on transfer not standard expected Information sharing between Police and CS MASE meeting did not take place with no attendance from education. Minutes not made available to partner agencies ***Supervision*** Limited opportunity for reflection within supervision	Support CS workers increased learning around CSE (screening tool, levels, direct work) More rigorous approach in assessing and monitoring children at risk of neglect Greater understanding and use of assessment tools in relation to neglect. MASE meetings- minute takers available, minutes sent out timely, set review meetings. Greater consideration of non/disguised compliance and analysing potential for change in parents. Tighter transfer between CS teams Undertake supervision that supports more reflective practice and challenge.	Build strong links and understanding of Early Help Understand the Early Help engagement journey Regular liaison between partner agencies to share new and updated information in respect of families agencies are working with. Discuss thresholds to assist in risk sensible decisions Joint training in areas such as CSE and Neglect

	Effectiveness of Interventions Assessment of progress of intervention and positive impact on child, reduction of risk. Parental non-compliance recognised and addressed ***Supervision*** Children central to supervision process, regular supervision and management oversight, supports progression of case.			
Education Provider Services	***Quality and Timeliness of information sharing*** Information sharing protocols followed and understood. ***Awareness of thresholds and referral processes*** All schools audited used the threshold guidance to support referrals and know how to make referrals including out of hours.	***Quality and Timeliness of information sharing*** Almost all cases saw a change in social worker who did not hold the relevant information. Staffing issues in different agencies caused delay in meetings taking place. Information is not always shared from all agencies.	Formal task management process needs to be developed in every educational setting which offers formal professional challenge. Education to chase and escalate concerns with appropriate agency if minutes are not sent within specified timeframe Escalate concerns if	Communication and information sharing to happen in a timely way. Minutes need to be circulated promptly with appropriate actions/ Prioritise attendance at review and core group meetings Feedback to referrer even when there is no further

	All practitioners have taken action to pursue feedback. The practitioner knows where to get advice if clarification is needed ***The voice of the child*** What life is like for the child has been considered. The child's wishes and feelings have been gathered in an age appropriate way. Where appropriate diversity and disability issues are identified appropriately. ***Effectiveness of Interventions*** Interventions assessed and action taken when interventions not working. Where the chair is robust there are clear actions and a thorough understanding of the case.	Inconsistency of social worker at meetings, records and minutes not always circulated. ***Awareness of thresholds and referral processes*** Don't always receive feedback. Unable to keep a copy of referral form as it cannot be printed or saved. ***Supervision*** Task management is very varied through-out schools. Outcomes of decision making are not always recorded or robust. Formal professional challenge is not evident in all cases.	agencies are not attending meetings	action Consistent social worker and members of staff assigned to cases wherever possible.
Solihull Community Housing	***Quality and Timeliness of information sharing*** Agency involvement/sharing information and engagement/contribution to meetings.	***Awareness of thresholds and referral processes*** Practitioners did not know where to find the threshold guidance and this isn't used to inform referrals.	Briefing to frontline professionals about the threshold guidance Reference to be made to threshold guidance in	Early engagement with SCH where housing issues involved Consistent feedback from referrals

	Application of information sharing protocols Evidence of frequent, well administered meetings (but communication breakdown led to practitioner missing a couple of meetings ***Awareness of thresholds and referral processes*** Practitioners aware of how to make safeguarding referrals, including out of hours services. Practitioners are clear about getting consent and know where to seek advice/clarification around referrals. ***The voice of the child*** Housing practitioners generally work with adults (parents) but clear evidence that case workers mindful of 'what life is like' for child. Diversity & disability issues are consistently identified, recorded & considered.	Feedback not always received from referrals and action to obtain feedback is not consistently carried out ***The voice of the child*** Wishes and feelings of the child not consistent with the nature of the practitioners role	decision making authorisation procedure Compliance to be monitored Staff training under the revised multi-agency training framework Improve accessibility of all safeguarding procedures Review supervision and support framework Keep engagement of MASH under review	Timely action to resolve any issue over cross-authority social care responsibility Build on engagement with MASH, revised DA triage and Early Help framework

	Effectiveness of Interventions Housing practitioner knowledge of the effectiveness of social care interventions over a period of time is limited. However, example where housing officer involved in frequent multi-agency child protection meetings demonstrated that interventions had a very positive impact on children of the family ***Supervision*** A framework of '1 to 1' meetings and internal case audits is in place. The child is central to decision making, both in the safeguarding context and in respect of the legal duties owed under housing legislation.			
Early Years	16 standards met or exceeded – standards specifically relating to the practitioner or internal issues	S1, 2, 4, 8, 15, 17 not met Common issue is that standards rely on involvement of lead agency to ensure multi-agency	On-going review of Safeguarding policy and procedures Training and development	Keep the child at the centre Systems, structures and processes which improve organisation, communication and

	Practitioner pro-active and determined Comprehensive records Child is kept at the centre	working Lack of communication and information sharing		information sharing Follow agreed LSCB procedures Be pro-active
Voluntary Sector	All standards except two were fully met. ***Quality and Timeliness of information sharing*** Cohesive core group work and information sharing ***Awareness of thresholds and referral processes*** Thresholds understood and followed ***Supervision*** Children central to decision making	***Awareness of thresholds and referral processes*** Lack of clarity over the role of the practitioner ***Supervision*** The worker involved in the case was not have frequent, formal supervision.	Revisit training and policy wording relating to consent Mandatory formal supervision when working with children who are subject to CP plan	Improve attendance/reports at meetings Ensure agency terminology understood Central amalgamation/chronology of information Consider VCS
SIAS	Standards met in both cases: S1, S3, S5, S6, S7, S9, S10, S11, S16, S17, S19, S20, S21 Standards met in one case: S2, S4, S12, S15, S18, S22	***Quality and Timeliness of information sharing*** Poor attendance by agencies at core groups and dates/times of meetings not always communicated Change of social workers Meetings cancelled	Each branch of SIAS has a Safeguarding Lead. Leads responsible for ensuring training is up to date, provide support to safeguarding cases, facilitate supervision, look at referrals to children's services, quality assure	Hold regular forums for partner agencies Joint supervision/ALS Easier communication routes Increase frequency of professional meetings and

		Meetings not always attended by key agencies Delay in receiving minutes Action plans not clear ***Awareness of thresholds and referral processes*** Feedback not given in timely manner after referral is made ***The voice of the child*** Clinical notes adult focused and do not reflect voice of the child ***Effectiveness of Interventions*** Frequency of core groups irregular and no contingency plan ***Supervision*** No evidence of challenge in supervision record. Evidence of suggestions made by supervisor not documented.	conference and court reports Internal annual audit re safeguarding practices 'Think Family' and 'Right Service, Right Time' training continues to be delivered across the partnership.	joint visits

Appendix 3 – Single Agency Improvement Plan

Agency	Actions to be Taken	Progress	Completed?
CCG	• Training to include the thresholds criteria in scenarios • Awareness raising of the thresholds criteria is taking place		
HEFT	• Heighten the awareness and cement the use of the thresholds document • Consider auditing the feedback process and raise concerns to partner agencies if indicated • Challenge practitioners and the raising the voice of the child during CP and managerial supervision. Promote practitioner confidence around this.		
Police	• Engage and understand • Predict and prevent • Respond and resolved • Evaluate and innovate		
Children's Social Work Services	• Support CS workers increased learning around CSE (screening tool, levels, direct work) • More rigorous approach in assessing and monitoring children at risk of neglect • Greater understanding and use of assessment tools in relation to neglect • MASE meetings – minute takers available, timely distribution of minutes, set review meetings • Greater consideration of non/disguised compliance and analysing the potential for change in parents • Tight transfer between CS teams • Undertake supervision that supports more reflective practice and challenge		
Education	• Formal task management process needs to be developed in every educational setting which offers formal professional challenge		

	• To chase and escalate concerns with appropriate agency if minutes are not sent within specified timeframe • Escalate concerns if agencies are not attending meetings		
Solihull Community Housing	• Briefing to frontline professionals about the threshold guidance • Reference to be made to threshold guidance in decision making authorisation procedure. Compliance to be monitored • Staff training under the revised multi-agency training framework • Improve accessibility of all safeguarding procedures • Review supervision and support framework • Keep engagement of MASH under review		
Early Years	• On-going review of safeguarding policy and procedures • Training and development		
Voluntary Sector (SOLO)	• Revisit training and policy wording relating to consent • Mandatory formal supervision when working with children who are subject to CP plan		
SIAS	• Each branch of SIAS has a safeguarding lead • Leads responsible for ensuring training is up to date, provide support to safeguarding cases, facilitate supervision, look at referrals to children's services, quality assure conference and court reports • Internal annual audit re: safeguarding practices, 'think family' and 'right service, right time' training continues to be delivered across partnership.		