Northamptonshire Safeguarding Children Board

Extraordinary Multi-Agency Case Audit (MACA) – Referrals into MASH

Summary Report

1. Background

The Quality Assurance Sub Group undertakes an annual programme of multi-agency case audit activity which are themed against areas of particular interest for the Local Safeguarding Children Board.

In February 2018, Northamptonshire Police requested a deep dive exercise into 60 cases that were referred to the Multi-Agency Safeguarding Hub (MASH) during 2017/18 in order to assure Board and agencies that safeguarding process and practice was working well across the partnership. Due to the large number of cases to be audited and to allow agencies to undertake their audits, a multi-agency meeting was held on 11th April 2018 to discuss the findings.

2. Methodology

Partners were asked to undertake an audit on each of the cases known to their agency and to provide a summative report to include an overview of findings: what was working well within their agency; what needed to improve; and what restorative actions needed to be put in place to address any concerns, together with a timeline for completion.

3. Summary Findings discussed at the MACA meeting on 11th April 2018

3.1 Findings

- There was a high level of domestic abuse recorded throughout cases and concern around how well systems work;
- Some underlying themes were similar to those previously identified through MACA, for example: -
  - Being able to understand daily lives of pre-verbal children;
  - Inconsistent recording of the voice of the child;
  - Importance of recording information and chronologies;
  - A high number of re-referrals to MASH;
  - Information-sharing needs to be improved in specific areas including CPIS, domestic abuse, S47 and MARAC and onward actions;
  - Lack of professional curiosity, including an investigative mind-set;
  - Not engaging with all members of the family (often only mother);
  - A need to focus on Targeted Early Help as well as Children's Social Care referrals and
  - Professional challenge via Dispute Resolution procedure needs increased focus.

3.2 What's working well?

- Northamptonshire County Council – Early Help & Prevention found a high proportion of cases 'met good';
- Northamptonshire County Council – Children's Social Care found that, in some cases, there was a good response to risk and of the direct work undertaken with children and families. There was also evidence of joint visits with Heath Visitors and use of Signs of Safety within case notes. In addition, there was good management oversight in a number of cases;
- Northamptonshire Healthcare Foundation Trust (NHFT) found that 44/60 cases evidenced that Health were part of decision-making processes and there was good communication between agencies;
- NHFT identified that the neglect toolkit had been completed to inform a case conference;

- Northamptonshire Police - 48 of the 56 cases identified 'met good' and the Public Protection Notifications (PPNs) are working;
- Kettering General Hospital ensure case conference outcomes form part of patient records;
- Police make good use of the DASH, although this isn't believed to be an automated process for other agencies;
- Youth Offending Service – all 4 cases audited 'met good' and evidenced good engagement with young people;
- Nene & Corby Clinical Commissioning Groups – of the 41 cases identified, responses were received from 31 GP Practices and safeguarding appears to be well embedded. Multi-Disciplinary Team meetings were positive and GPs were acting on concerns;
- There was positive commitment shown from partners and audits undertaken were generally good and
- It was positive to see implementation of Signs of Safety in place in Children Social Care audits.

3.3 What are we worried about?

- The management of Section 47 is an issue for Children's Social Care and further bitesize training is needed to address identified gaps. This includes clear, SMART analysis and confusion regarding decisions;
- Agencies are not always using family information appropriately i.e. not gathering a holistic or historic picture. It was acknowledged that implementation of Signs of Safety will help to improve practice across the partnership;
- More awareness and understanding of the risk domestic abuse poses, together with greater understanding of the MARAC process is needed, including consistent responses;
- Lack of professional curiosity / investigative mind-set and follow up; this is evidenced in a number of agencies. The dispute resolution procedure should be utilised more often;
- Professionals do not make good use of chronologies;
- Early Help Assessment recording on Capita needs to be improved;
- When working with infants, there is over-reliance on listening to parents, rather than observing baby/infant;
- There continues to be inconsistent recording of the voice of the child and too much focus on listening to parent(s) rather than listening or observing the child;
- NSCB Pre-birth guidance is not fully utilised in respect of recording the voice of the child;
- A lot of work in Early Help focuses on the parents, not necessarily the needs of the child;
- The Domestic Abuse Notification Scheme could be extended to include acute settings (currently only Health Visitors and School Nurses are informed);
- There needs to be increased confidence from partners to professionally challenge colleagues across agencies including clarity of roles and responsibilities and
- Improved awareness and use of the NSCB Conflict Resolution Policy is needed to support all agencies to progress cases more effectively and effective challenge is in place, including use of supervision.

3.4 Summary of Identified Gaps and Improvements Required across the Partnership – Summary

3.4.1 Policy and Procedures

a. NSCB Conflict Resolution Policy – change in partnership culture and ability to challenge in a respectful manner. This is an area of concern.
b. Pre-birth Guidance and Pathway – Identified as a concern – needs more scrutiny from Board.

3.4.2 Information sharing

a. Child Protection Information System (CPIS) - is this in place and working effectively across all health partners? More awareness of the CPIS system and process is needed across the partnership;
b. Health to review how information is shared between agencies, including health partners – to be shared at Strategic Health Economy Forum;
c. The Domestic Abuse Notification Scheme could be extended to include acute settings (currently only Health Visitors and School Nurses are informed);
d. Domestic Abuse information sharing - ensure that, if the record is not understood, partners have the confidence to challenge;
e. Issues are not escalated appropriately from Multi-disciplinary Team (MDT) meetings and GP practices;
f. Issue for GPs regarding appropriate explanation about why cases are sent to MASH. Further awareness of System One and a pro-forma needs to be created for GPs;
g. DASH & automated information sharing process needs further exploration.

3.4.3 Understanding of the Section 47 Enquiry process

a. This is an area of concern and needs scrutiny at Board level and is a key feature of the current operational improvement plan.

3.4.4 Domestic Abuse

a. How well is the MARAC process understood across partnership agencies?
b. Understanding the impact of domestic abuse between Adult and Children Services;
c. Notifications – are these reaching all agencies, including acute settings?

3.4.5 Key Line of Enquiry – Early Help

a. Is there need for additional governance at Board level in respect of Early Help?
b. There is a need for increased operational visibility of what EH is available in the partnership.

3.4.6 Voice of the Child

a. Listening to and recording the voice of the child and
b. Child-focused and issue of observing / recording pre-verbal infants.

3.4.7 Record Keeping

a. Recording of information for perpetrators of domestic abuse on children's records. This also relates to Conflict Resolution - as the issue has not been challenged;
b. Information regarding children on plans and strategy meetings are not updated on Police files;
c. PPNs do not always capture who is involved.

4. Next Steps and actions

a. Quality Assurance Sub Group to address gaps and improvements – as detailed above;
b. Improved knowledge of domestic abuse and how it affects the family is needed, including greater understanding of MARAC processes;

Northamptonshire Safeguarding Children Board acknowledge that this MACA was an intensive piece of work and would like to thank all agencies and GP practices for the time taken to audit the high volume of cases, which in turn will provide valuable learning across the partnership.