SESLIP Regional Improvement
SCC contacts and re-referrals audit report

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Introduction

1. This report is for Southampton County Council (SCC) Children's Services Improvement Board, 20 March 2023. The purpose of this audit report is to provide a summary, analysis, and feedback on 66 case file audits completed on children who were referred to SCC on two or more occasions or where information was passed through a contact to SCC by the Police. The case file audits were completed in February 2023 by Hampshire County Council's (HCC) Sector Led Improvement Team (SLI), an HCC Multi-Agency Safeguarding Hub (MASH) manager and three Southampton Children's Services managers. These managers formed a regional team as this work was carried out under the umbrella of the Southeast Sector Led Improvement Partnership (SESLIP) small packages of improvement work.

Aims and Objectives

2. The aim of this work is to provide SCC with an independent overview and evaluation of aspects of the work completed mainly by MASH and Assessment Teams, as well as long term teams, for contacts and re-referrals. The focus is to broaden understanding of the reasons behind the volume of contacts from the Police and a high number of children's cases re-referred to SCC, through auditing of contacts and re-referrals made to SCC. The areas within scope included:

- Quality of contacts and referrals made to SCC by Police
- Quality and timeliness of checks completed within MASH
- Referral and triage process within MASH and assessment teams
- Management oversight
- Threshold decisions made within MASH
- Quality of practice
- Re-referrals

3. It was agreed with SCC that the audits completed would be of contacts received and closed, referrals and re-referrals that progressed for decision making to a manager within MASH. SCC provided 100 children's cases (50 contacts and 50 re-referrals) to the regional auditing team and of these, 80 cases were randomly selected to audit. Of the 80 cases, 66 cases were audited. HCC managers were provided with user access by SCC to remotely access the case management system, Care Director. Auditing took place between 6-12 February 2023. On the first two days an SCC manager joined HCC auditors face to face at an HCC building (where HCC MASH is based) to carry out the auditing and to also be present to support with any access issues.

Methodology

4. The list of cases audited had been referred to SCC in the previous six months from January 2023. A contact is made where Children's Services is contacted about a child, who may be a Child in Need, and where there is a request for general advice, information or a service. At any time, a contact may become a referral if it appears that services may be required.

5. The sample of contacts/referrals used were of cases referred by the Police. This is because SCC identified their highest number of contacts/referrals is from the Police and that the figures were higher in comparison to their statistical neighbour and other Local Authorities sharing the same Police Service.

6. The 66 case file audits were undertaken using a Microsoft audit tool. The audit tool was designed to have a narrow focus on specific elements of the MASH through to the assessment process. The audit questions were shared and agreed with SCC prior to auditing taking place. The audit tool used questions attempting to understand and form a view about the overall quality of the referrals and case recording, the information gathered, the quality of risk analysis and management oversight and the overall timeliness of case management. In cases where safeguarding concerns were identified, an escalation process was agreed. Out of the 66 cases audited, an HCC auditor escalated one case to SCC senior management. This was agreed with an SCC manager who was on site at the time of the escalation and took immediate action to contact SCC MASH. SCC has since responded to the formal escalation with clear actions taken.

Findings

Contacts/referrals

7. Of the 66 cases audited 35 (53%) were contacts/referrals. Overall, out of the 66 cases audited 43 (65%) were contacts/referrals from the Police. Of these contacts 39 (90%) out of the 43 contacts/referrals auditors reported that the contacts from the Police were clearly recorded. The primary category of the reason behind the highest number of contacts/referrals was identified as domestic abuse at 20 (30%).

8. Records audited were chosen at random. However, it was noted that there were contacts and referrals concerning the same large families. An example was a family of six children that had moved from another local authority (OLA). Prior to the family moving, the OLA had made the decision to convene an Initial Child Protection Conference. SCC initially screened the family as meeting the threshold for Early Help (EH) support. Multiple contacts and referrals were then received, the case was subsequently assessed and open under Child in Need planning. Given the nature of the concerns which involved physical abuse, and contextual safeguarding concerns, it was perceived by auditors that the threshold for statutory intervention had clearly been met initially. Positively, it was noted by auditors that now the family are open within the Social Work With Families team there is a holistic family assessment, regular supervision and reflective visits considering each child's needs individually and as part of the family.

Re-referrals

9. Re-referrals consisted of 31 (47%) of the cases audited. The primary category of most of the cases re-referred was neglect 10 (32%) followed by domestic abuse and physical abuse which both amounted to 6 (19%) respectively. For a number of families (32%) an assessment had been completed prior to the case being re-referred.

10. When analysing previous episodes of Children's Services involvement, it was seen that when children had received support under child in need or child protection planning, they were less likely to be re-referred. Only four (13%) children out of the 31 re-referrals had previously been subject to Child in Need planning or Child Protection planning. This suggested that children who had longer term support previously were less likely to be re-referred.

11. When children were re-referred, 21 (68%) of the 31 cases had been re-referred within 0-3 months of previous involvement. Auditors reported that in some cases a contributing factor was that it appeared appropriate thresholds had not been applied initially. The application of thresholds was deemed to be clear in response to the contact/referral in 36 (55%) of cases audited. Decisions were made for children to be passed to other teams including Early Help and the Brief Intervention Team, without MASH checks. Auditors questioned if support was being offered with sufficient checks to ensure all information had been gathered, to ensure that the right support was offered at the right time, thus reducing the likelihood of the case being re-referred.

12. The audits also identified that in some sibling groups when there had been contextual safeguarding concerns, only one child had been assessed, with the impact on the other siblings not considered. This appeared where the Young People's Service had been involved. For example, in one family a strategy discussion and section 47 investigation was completed for one child in the family group. Following this several referrals were received from partner agencies regarding other children in the home. In another family while one child was open, the impact of domestic abuse for the siblings was not identified by Early Help who incorrectly interpreted a Police report. Auditors questioned if the assessment of risk, when Police reports are received, should sit with the MASH managers who may be better placed to make this assessment.

13. In 23 (74%) of re-referrals received, the concerns had been the same as the previous referral. In 20 (30%) of children's cases domestic abuse was the primary reason for the cases referred and it was noted all of these families were already known to Children's Services. It is recognised that there are complex families that despite appropriate support offered, further referrals are unavoidable, however for most cases re-referred it was considered that appropriate interventions that support the family holistically, may have reduced the number of re-referrals received for the same reasons.

14. However, it was observed by auditors that many families had complex and long-standing challenges impacted by poverty alongside struggles in accessing resources.

Management Oversight

15. Positively all children's cases had management oversight prior to progressing to MASH, for further work or closing. Forty-three (65%) of these showed analysis and rationale for decisions made. Within the cases that were not identified as showing a clear analysis the reasons highlighted included that the management oversight

had been mostly brief, or lacking rationale and further exploration of the risks including historical information was required.

16. Auditors noted that for some cases it had been challenging to understand how children's history was presented in the management summary. The information was not always in a chronological order and appeared to have been largely copied from case notes. This impacted the ability to easily identify patterns of concern, resulting in a weaker analysis. It is important to recognise that within SCC's Children's Resource Service (CRS), managers gather the information as well as analyse and make decisions on the next steps. This is a time-consuming activity, thus impacting the quality of information gathered particularly in a fast-paced environment like a front door service.

Timescales

17. It is positive to highlight that 65 (98%) of cases audited had been screened within 24 hours of being referred to SCC. In many of these cases it was noted that cases had been screened within a few hours of being received which evidences an urgency within CRS to deal with the cases as they are received.

Thresholds

18. In seven of the 66 cases audited, strategy discussions were held. This was also an area of strength as six (86%) out of the seven strategy discussions were held within timescales with five (71%) clearly having actions recorded following the outcome of the strategy discussions. However, in response to the contact/referral in 30 (45%) out of 66 cases auditors noted that the application of threshold was not clear. In most of these cases it was highlighted that reference had not been made to SCC's threshold pathway document to indicate how threshold decisions had been reached.

Case recording

19. It was noted by auditors that some of the language used within the children's files was not child focused. One auditor highlighted a case of a teenager who had previously had a pregnancy termination being described as placing themselves at risk of harm and placing blame on them. In another case a young person had been refused support by the Young People's Service because their older sibling was already receiving support. It was recorded on their case file that, 'due to the referral not being in line with Destination 22' they would not receive support.

20. The use of acronyms was also seen to be widespread within the contacts, re-referrals and decision making at the front door. This made navigating the case recording a challenge for HCC auditors and the child's journey through services was not always clear. However, strengths-based language and child focused recording was observed by the longer-term teams. Evidence of writing to the child was observed. Where this was used it was immediately apparent that there were less abbreviations, and the readability of the record was apparent.

Front Door processes

21. Most of the cases 59 (89%) that were referred to SCC did not progress to have MASH checks completed. Of these 10 (15%) were cases where strategy discussions were held. Only seven (11%) of cases had MASH checks completed, suggesting an under-utilisation of completing these checks for informed decisions to be made that will support in assessing the risks/needs as well as identifying if further intervention is required from SCC. Within SCC if a case is perceived by CRS as meeting threshold for a child and family assessment at the point of contact or referral the case can bypass the MASH process and is progressed for an assessment to be completed. Whilst it is acknowledged that this prevents a delay in children and families receiving the support required, if not used appropriately this can impact the consistency and application of thresholds.

22. In one case it was noted that a contact from the Police progressed straight to the Early Help Service who were already supporting the family. The MASH manager did not complete a case summary or checks. It was missed by the Early Help Manager that the children were in the household at the time of a domestic incident (recorded at the top of the Police report). It was considered this was a missed opportunity to complete comprehensive checks and analysis at that stage. The children were subsequently re-referred for similar concerns and had a child and family assessment.

Escalations

23. Within this audit exercise only one case was escalated for safeguarding concerns. This was relating an unborn child's case that had been closed, the mother had been residing in a tent and had a history of having violent relationships. The case had been closed on the basis that the pregnancy had not been confirmed. SCC acknowledged that more efforts should have been made to engage with the mother. There was a reliance on other agencies to re-refer if the pregnancy was confirmed without discussion with other agencies of this outcome. SCC initially responded promptly requesting additional checks were completed with housing.

Conclusions

24. There were clearly areas of strength identified within this audit exercise. This was mainly within the contact stage where 98% of cases were screened within 24 hours of being referred to SCC. This evidenced that SCC's front door service responded promptly to children and young people contacts and referrals in this sample group.

25. When strategy discussions were held, they were held within timescales with clear actions recorded. Most notably, all cases audited had prompt management oversight recorded after being screened. This confirmed that there was a high level of oversight from managers at the initial stage of referrals being received.

26. However, it was noted that there was a lack of consistency in the quality of management oversight recorded. This was identified as sometimes lacking in analysis, exploration of risks and clear rationale of how decisions had been

reached. It was considered that there was a lack of clear process for collation and analysis at the initial stages of contacts to allow MASH managers to make management decisions.

27. For re-referrals, decision making was largely taking place without full MASH checks. For some children this resulted in their records being closed as families were said to not want or refuse assessments, with agencies not aware of the referrals. It is recognised that multi-agency communication supports a clearer understanding of the risks and needs of the children and families from the onset to ensure that the right support is offered at the right time. This can also link to ensuring the appropriate thresholds are applied.

28. The high number of contacts/referrals received from Police was an area identified as an area of concern by SCC. From the sample of cases audited, most of contacts were clearly recorded by the police which would have provided SCC the relevant information needed to make decisions on how the cases would progress. Most families were already known to services, and many families' needs were linked to complex histories and challenges which required preventative work.

29. Re-referrals is an area that requires further scrutiny given that in the sample of cases audited, there were significant numbers of cases that had been re-referred within a short period of previous involvement for the same reasons or linked to another child in the household already open to the young people's service. It was observed by auditors that concerns of children residing within the same household were assessed separately in MASH, especially when there were contextual safeguarding concerns, that were seen to have an impact on family group.

Recommendations

30. The following recommendations are made for SCC to consider helping support practice improvement in this area:

- At the contact stage for there to be a consideration of the use of the support workers to gather the information needed to aid managers with focusing on decision making. This could improve the quality and consistency of decision making and proportionate use of management expertise.

- For staff within CRS to be offered training on the application of the threshold document and the use of the SCC's threshold document. A copy of the threshold document to be made easily and readily available to staff.

- Children in the same household to be considered together within MASH and on allocation, to ensure all the children's needs are addressed individually and as part of their family unit.

- To encourage strength-based practices that are child focused for consideration to be given on case notes being written to the child. This will reduce the use of language that is potentially victim blaming and jargon within children's files. Training for staff could support this.

- Further scrutiny and follow up to be given to re-referrals by considering six monthly audits to be completed within this area by SCC.