Cheshire East Local
Safeguarding Children Board

LSCB Step Up Step Down Partnership Audit

July 2018

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Executive Summary

This audit was undertaken to assess the quality of our support to children and young people where the case is Stepped Up or Down in relation to the Threshold of Need in order to improve outcomes and practice in this area.

Eight cases were audited which covered a range of ages and levels of need. Each agency audited their own agency's involvement based on evidence in their case records against a common audit tool. They all made a judgement on the quality of partnership working. Agencies then discussed their findings and the audit process in a multi-agency meeting.

The audit findings are summarised below in terms of our strengths and areas for improvement.

What are we worried about?	What's going well?	What do we need to do?
• Step down is not consistently informed by re-assessment. • Sustained change is not routinely examined and evidenced at the point where step down is applied. • Evidence of a delay in escalating a housing issue has meant that Housing was unable to intervene to prevent an eviction. • The Guidance for managing Child Protection/Child in Need multi-agency meetings is not consistently applied resulting in delays in receipt of plans and meeting notes. The Audit panel did question if it is cost effective to have practitioners process this paperwork. The equivalent Child Protection Conferences process works, should a similar business support resource be available for CiN meetings? • The current step down guidance section 2 starts from a Children's Social Care process and should focus on a multi-agency approach to decision making that is informed by re-assessment and evidence of sustained change. • 2 cases evidence step back up happening more than once.	• A range of agencies are using screening tools. • The Voice of the child is well represented in several agencies' practice via the Childs words, presentation and the evidencing of the lived experience. • At step up there is consistent use of screening and assessment tools and strategy meetings. • In a couple of cases there was evidence of sustained change. • Evidence of improved outcomes in half of the cases. • Working together strengths. • The Ages and Stages Questionnaires are being routinely used by Wirral Community Trust.	• CiN Safety plans must evidence the criteria for step up or step down. • Wider partnership to be informed about the Ages and Stages Questionnaire and how it can inform their work. • Inform practitioners about the Housing referral requirements. • Partners to assure the board that they are monitoring the application of the Guidance for managing Child Protection/Child in Need multi-agency meetings by their practitioners. • Ask the Board if they are prepared to consider a business support resources for CiN meetings similar to the CP process. • Update the step up step down guidance to include a multiagency approach to decision making that is informed by re-assessment and evidence of sustained change. • Repeat plans assure the board that wider work on this includes CAF/CIN.

In 2015 the LSCB conducted a Step down Audit. This 2018 audit has identified that further work is required to ensure practice address the following recommendation from 2015:

- Before a final decision to step down is taken examine the evidence that a child/young person's needs have been met, that any improvements are felt to be sustainable, and that there are contingencies in place;

Context

The Local Safeguarding Children Board (LSCB) agreed that a multi-agency audit should be undertaken to assess the quality of our services to inform and drive improvements to our services to improve outcomes for our children and young people.

Audit Methodology

The audit tool has been further developed and strengthened by incorporating the Signs of Safety approach to practice. It has been adapted for Step Up/Down.

Eight cases were selected randomly from those cases open to Children's Social Care in the last 6 months where they were stepped up or stepped down.

Partner agencies were asked to check their records to see if the child/ young person or parents were known to them, and if so to complete the audit tool, exploring the quality of their work and its impact on the child/ young person. The Safeguarding Children in Education (SCiES) team liaised with schools and offered support in completing the tool. Auditors were asked to consider only the last six months of their agency's involvement.

A multi-agency meeting was held to explore the audit information and to identify what's going well? What are we worried about? And what do we need to do? Feedback on the audit process was also sought during this meeting and is detailed below.

Learning for Multi-Agency Audits

There were a number of points highlighted for learning from this process:

What are we worried about?	What's going well?	What do we need to do?
• The audit tool is difficult to complete if an agency has only had limited involvement in a case. The current template is designed as a one size fits all. • A number of audit submissions went outside of the 6th month period of the audit. The audit template instruction does emphasis the requirements to stay in that period.	• Attendance by partner agencies even when they have had limited case involvement provides the opportunity to contribute to thinking if wider involvement would have been constructive. • The collation of the cases paper for the chair was considered useful; it would also be useful for all those attending.	• Share the collation of the cases paper with all attendees next time. • Consider how to encourage audit template completion to focus around specific time points or issues.

	• The scaling of cases provides a useful discussion point to compare views. • Identifying an agency to provide a brief introduction to each case worked well. • The quality of the chairing helped the flow of the discussions with it being clearer the chair had done preparation work on each case.	

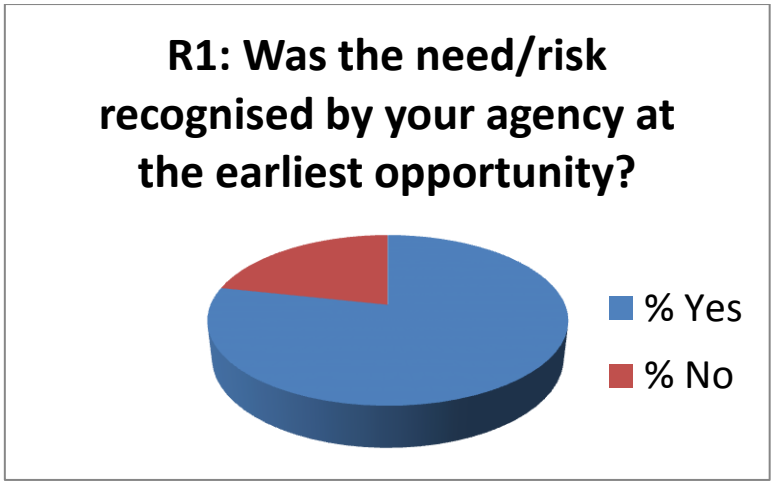
Findings from the Audits

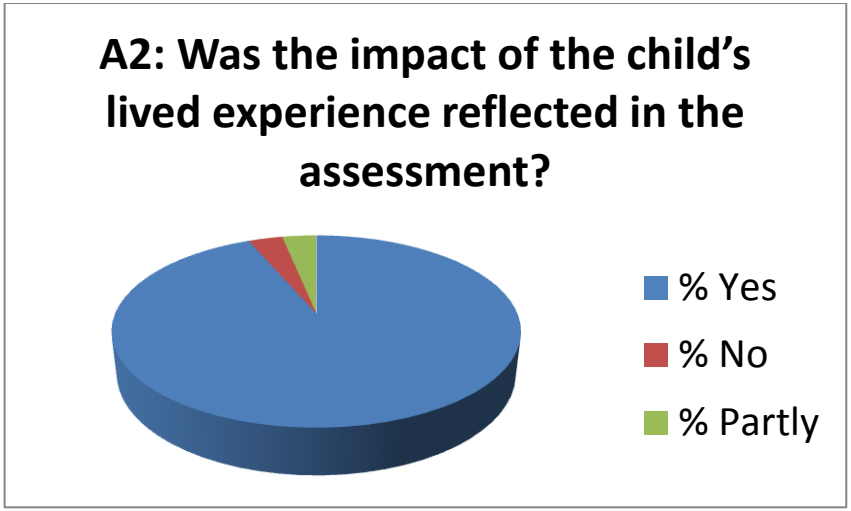
The Agency Audits identified that for the 78% of cases, a need was recognised at the earliest opportunity (as shown in the chart to the right).

In 35% of the audits the agencies identified that practice tools were used to evidence level of need (for example Graded Care Profile or CSE Screening Tool).

88% of audits found that the assessment identified what was working well in the family.

The audits found that in 97% of cases, the response was appropriate when the need/risk had been identified.





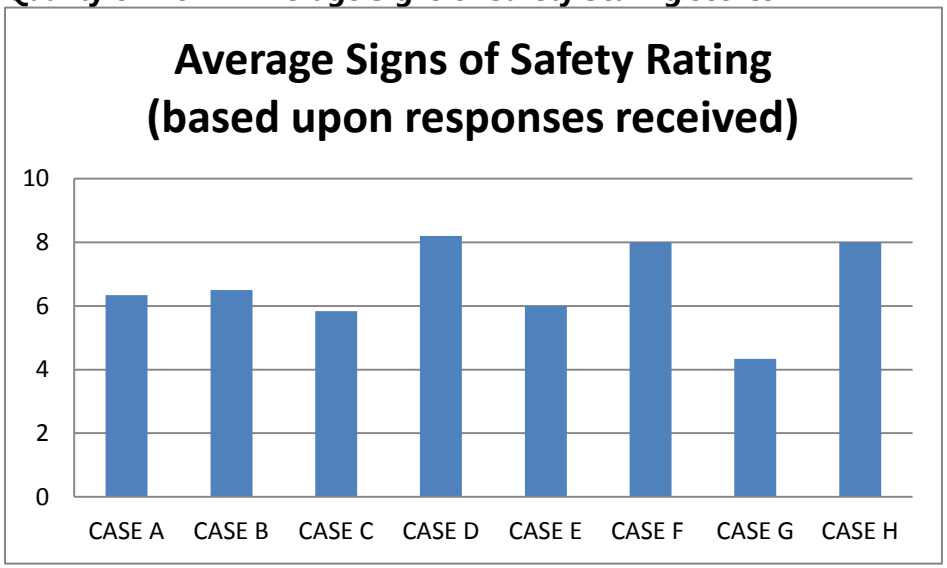
You can see from the chart to the left, that in 94% of audits, the impact of the child's lived experience was reflected in the assessment. 3% said this was not the case and 3% said that this was partly the case

85% of audits found risks were clearly understood (12% identified that they weren't and the other 3% said this was only partly). In 91% of the cases, it was identified that the decision making was clear. 85% also found that information was appropriately shared.

In 45% of the cases, it was found that the children were consulted/involved in the assessment and that their wishes and feelings were clear (52% said gave the answer of no and 3% gave the answer of partly)

Auditors considered that in 64% of the cases the work undertaken resulted in improved outcomes for the child, 32% said No and 4% said that this was partly achieved.

Quality of work - Average Signs of Safety Scaling scores



Auditors were invited to apply a Signs of Safety scale from 0 to 10.
10 means the quality of the work overall is outstanding and 0 means that the quality of the work overall is inadequate.

The graph to the left illustrates these scores

In addition, each case was also considered against the Ofsted scaling of Outstanding, Good, Requires Improvement and Inadequate. This question was asked at the end of each set of questions in the following categories:

Quality of the Recognition
Quality of the Assessment
Quality of the Planning and Intervention
Quality of Co-operation
Quality of the Impact
Quality of work for your agency

When looking at the average scores for these responses
1 case had an average score of Outstanding

7 cases had an average score of Good
0 cases had an average score of Requires Improvement
0 case had an average score of Inadequate

Recommendations

	Finding	Action	Lead	Date for completion	Outcome
1	CiN Safety plans must evidence the criteria for step up or step down.	Seek assurance that the application of the Signs of Safety approach will CiN Safety plans must evidence the criteria for step up or step down.	Signs of Safety Board		
2	Wirral Community NHS Foundation (Cheshire East) are using the Ages and Stages Questionnaire and partners are not aware of what it is or how it can contribute to partnership working.	Brief the wider workforce via the LSCB frontline bulletin	Ruth Tucker		
3	A family with long standing issues will be evicted from their current housing. This could have been avoided with a timely notification to the Housing Team. Housing voiced concerned that a lack of knowledge of when to make a referral, limits their scope for intervening.	Inform Children Social Care practitioners via the Performance and Practice briefings.	Karen Carsberg		
4		Brief the wider workforce via the LSCB frontline bulletin	Karen Carsberg		
5	The Guidance for managing Child Protection/Child in Need multi-agency meetings is not being consistently applied. This is resulting in plans and notes not being available in a timely manner to support practice.	Seek assurance from Board member's that their practitioners are aware of the Guidance for managing Child Protection/Child in Need multi-agency meetings and are actively applying it in practice.	Alistair Jordan		
6		Ask the Board if they are prepared to consider a business support resources for CiN meetings similar to the CP process.	Kate Rose		
7	The current step down guidance section 2 commences with a Childrens Social Care process. It should reflect a multi-agency approach to decision making that is informed by re-assessment and evidence of sustained change.	Update the step up step down guidance to focus on a multi-agency approach to decision making that is informed by re-assessment and evidence of sustained change.	LSCB Policy and Procedure sub-group		

8	There were 2 cases stepped down where it was evidenced that it was not sustained and therefore returned to Child Protection (in one case the young person was subject to a CP Plan on 3 different occasions)	Seek assurance from wider work on represent plans that this includes CAF/CIN.	Jacquie Sims		

Appendix A: Pen Pictures of the Children and Summaries

Case A

18 yr. old female. Been on CP plan on 3 different occasions for Sexual Abuse and Neglect Previously on CiN plans. Has been involved in CAF. Currently not on any plan. Known to CWP since 2012 to present. Concerns re self harm that led to surgery.

Overall Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• YP has none engagement with CAMHS therefore closed; she remained in and out between 2013 and 2016 then receiving trauma therapy. • This case was closed due to YP being 18 and on reflection it feels like it has been closed as she turned 18. Concerned as agencies involved long time and there wasn't an updated assessment and screening tools. YP seems isolated and so many changes of workers. • 2016 Self harmed that led to plastic surgery • 2016 disengaged from support and therefore CAMHS closed • Ongoing concerns, impact of self harm and no sustained change, element of none compliance • Number of missed appointments • Self medicating with amphetamines • Subject to 3 plans - What does S/G need to do	• Lot of good multi-agency work, joint visits with Social Workers. • Early year's team show good evidence from CAMHS. • Good discussions identified between Social Worker and Safeguarding Unit – each point there were discussions with CP IRO. • Consistent CAMHS worker. • Very positive interactions with Social Workers and YP – evidence of good relationship e.g. Birthday Card being sent on her 18th birthday • YP's needs at the centre of planning and her involvement in planning was clear – plan focussed on needs of YP - There are positives and indicators on her records of doing good support work • It is felt by all agencies that they did their best to support YP	• IRO unit have been discussing this case and as a result are in the process of using this to inform future practice, they have identified work required on challenging repeat plans. Now monitoring all cases when coming in again and discussed on monthly basis. • If a child has been on plan before and stepped down when it comes again, ask why it came off plan, what impact was and why there wasn't sustained change. • If been more challenging at second referral it may have changed second plan. Team manager needs to talk to service manager and escalate at earlier point • Step up – need to see what hasn't worked previously. • If plans are not circulated it each involved agencies responsibility chase it up.

to challenge? • Concerns re most recent step down, YP is 18, wasn't engaging with previous drugs worker, fears drug taking will continue or escalate. All agencies tried but were we focused on right things. • In May 2018 CP ended and went to CIN. Notes made asked should there be referral to adult LADO as YP working with vulnerable adults. We can't find any further info on this if it went any further. • Theme of agencies reports as not having meeting notes • No final meeting evidence • The CSE nurse was not made aware of the CSE concerns – no evidence that CSE concerns have reduced • Meeting notes – reports of them not being provided to agencies or not being provided in a timely manner.		• Need to revisit the escalation policy – this is currently being done by SCOG, but no more information – needs checking out to see if this is the case • It is important the Social Worker is supported by the multi agencies, they have high caseloads. In CIN meetings there is a lack of agency attendance, meetings take place and agencies then not fully aware of plan • There needs to be a meeting about this YP to assess her current needs. • Health now had designated worker for CSE. This nurse will be asked to ask them to make contact with the YP

Case B

13 yr. old male – has a brother and sister. Currently in care of grandparents. Concerns of grandparent's ability to protect as they were allowing mum to have unsupervised contact. Stepped down then back up.
CP Plan between August 17 and March 18 under category Emotional Abuse
CiN plan on and off between May 2006 and April 2014

Overall Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• First time around, grandparents were not fully engaged and didn't recognise the concerns • First time around – planning and intervention was adult focussed	• Clear assessments, impact noted and clear what needs to change. • Good understanding of needs of child evidenced	• Need to measure sustainability • Safety plan is key to use in each plan – signs of Safety have this and is a positive move forwards

• Some agency disagreements about levels of need - but this is not evidenced in meetings – not all agencies are able to disagree with authorities. There is difficulty when agencies don't agree on a decision • No evidence in plan for a plan of support for grandparents who are elderly and one has had an operation – for example, is there a need for respite for the grandparents? • No evidence of wider family to support grandparents	• School nurse supported children and grandparents to promote change • Good clear plan for step down – made clear what expectations were for all concerned • Clear contingency plan the 2nd time around • CP now using the SOS model and this is proving positive • Professionals worked well together with the family • Voice of the child is well documented	• There is a need to ensure that there is confidence of partner agencies to take responsibility and offer challenge where necessary • There needs to be a family conference for future planning

Case C

8 year old female. Family well known to Social Services (reportedly approx. 20 years)
CP plan twice under category of Neglect.
Currently on CiN plan between Sept 2009 until May 2014
Domestic Abuse, police visits intense work needed
Child with Disability

Overall Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• Domestic abuse • Mother not taking child to appointments • Family known to CSC for 20 years with no sustained change • DAFSU and MARAC referrals, mother breaching order • Stepped down from CP to CIN and then stepped back up again very soon • Mum feeling very overwhelmed and child has complex needs • Evidence of disguised compliance • Housing was not made aware that this large	• FACT 22 have given intense support • Health Visitor is now doing Graded Care Profile • Professionals meeting was held • Clear Action from the Chair • Good evidence of the voice of the child • Clear multi-agency working – family attended regular meetings • School chronology noted that the chair managed the conference well and it was made clear to mum what the implications would be • Lots of direct work noted on the SW file including lots of work to try and get the child's	• Wirral 0-19 said outcome of escalation needs to be shared at last meeting • School wish to be advised over the school holidays what is going to happen to the children • Safeguarding unit need to challenge when there is a request to step down and C&F assessment hasn't been updated • Liaison with housing is needed on this case • Housing to be invited to attend Practice and Performance workshops in order to share practice with SW's • Need to update assessment as a general rule on

family was due to be evicted – now it is too late for them to have appropriate intervention and likely they will be evicted. • No graded care profile used • No evidence of SW manager and manager of FACT 22 on notes • Anxiety from school as to what will happen to the family over the long summer holidays	wishes and feelings • Positive contributions from school • Good evidence of clear multi-agency working • Good attendance at meetings • Assessments were able to pull out positives and resiliencies • Risks made clear in assessment	a more regular basis including a clear plan as to when the GCP is to be repeated

Case D

4 year old female originally living with mum, concerns raised over other females in the house.
CP between Sept 2017 and May 2018 under category of Physical CiN in 2014
Previous drug misuse, lots of work with dad – now lives with dad.

Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• Previous drug misuse, • Neglect and emotional harm from the mother • CWA advised that they could not engage with the mother – no evidence to show that the SW was aware of this • Father was previous perpetrator of DA. • Mothers life very chaotic	• Police referred in due to concerns over the mothers relationships – this led to prompt referral to CP • Level of risk identified appropriately • CP plan included input from the father – child eventually lived with the father and being involved has led to positive turn around for the life of the child • Extended family included in the plan • Good multi-agency working • No drift or delay when SW changed • Extended family took child on holiday whilst dad was supported to detox and enabling him to have the child long term. This was coordinated with the father, Family Health professionals and the Social Worker. • School have very positive experience due to all	• A need to look at the process to ensure improved communication between CEDAS/CWA and SW – more effective closure needed to ensure that lack of engagement is evidenced in the next meeting • LSCB Bulletin to provide information on ASQ being used by health

	the support provided – family fully aware and plan worked well • Good evidence of SOS working well • Health Visitor did an emotional ASQ (Ages and Stages Questionnaire) with the child – Health are using this more regularly	

Case E

12 year old Male. Was fostered for 3 months then adopted two years.
Very traumatic life in Early Childhood.
Child runs away from home a lot and he is well known to British Transport Police – due to his behaviours he has to be restrained a lot
Started new school in April
Currently an open case under CiN

Overall Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• Child not engaging with the school nurse • Child Perpetrates DV towards mother and sister – he has threatened to kill his mother and sister – father working away a lot • Child not presented to MARAC due to his age • No evidence of safety plan for sibling • Assumptions being made by professionals involved in that other people are supporting the sibling • CAMHS only appear to be involved when the child is in crisis – apart from that, there is little going on • Child has no formal diagnosis despite Attachment Disorder and Post Traumatic Stress being mentioned in notes • No evidence of communication with health • Health were not involved when the case re-	• Good evidence of joined up working • Lots of contact with CAMHS • Lots of contact to post adoption team • Good communication from British Transport Police to SW • Positive joined up working in terms of therapy taking place when being assessed – parents taking child to weekly therapy classes • Currently an open referral and is being assessed • The family continue to pull together and attend appointments • Escalation has happened quickly as agencies identified the level of need to do so.	• Safeguarding Nurse to action that school needs to follow up on support • SCiES are going to look at the suitability of the new school as there is little known about if this is a suitable environment for this child (school out of area) • Professionals meeting is needed to ascertain all risks. • Needs of sibling and mother need to be assessed due to the complex needs of the child impacting on them

opened or closed – no chasing of parents to ask if there were any other health needs • CAMHS support not being offered due to the child having other provision • Concerns over the summer holidays as to what support is going to be put in place – this is an open referral at the moment		

Case F

8 year old male with complex disability – case referred due to mother requesting SW assessment of child with complex and rare condition that affects his health and development

Overall Judgement on the Quality of the Work: **OUTSTANDING**

What are we worried about?	What's going well?	What do we need to do?
• Need to identify additional care for child in conjunction with EHCP • Minor delay in March until May for funding • No social care information on the EHCP • School expressed concerns that they were not aware that a SW was involved with this young person	• Initial contact went well – assessment to look at support • Clear information sharing, good assessment • Good agency information • Extended family evidenced • Impact on the child included in notes	• SCiES to inform the school that no concerns were being raised – the mother was asking for additional support and was aware that the child was entitled to a Social Work disability assessment

Case G

3yr old male, attending nursery provision within school – history of mother drinking, depression and overdose, Domestic Violence. Mother has previously lost a child. Mother difficult to engage with services.
Currently waiting for worker allocation from Cheshire East Family Service

Overall Judgement on the Quality of the Work: **GOOD**

What are we worried about?	What's going well?	What do we need to do?
• Recent assault on mother from ex-partner has led to re-referral • No evidence of alcohol screening tool used with	• VPA shared by the police in a timely manner • On referral, good information gathering from nurse specialist in integrated front door.	• CHECS Service Manager to discuss this case with the CSC Team Manager to ascertain what plans were put in place for safety

the mother despite her admitting to using alcohol • No CAF currently despite Liquid Logic stating that school nursery doing a CAF – school agreed to do the CAF but have not initiated due to there being no handover from Social Worker • Mother in dispute with the nursery around fees – this may mean that they are not best placed to be CAF leads as mother may not engage fully • CAMHS not aware that mother took an overdose in December 2017 • No GP information on this case • RIC was completed by police but nothing done about engaging Domestic Abuse service • School will not be able to monitor due to school summer holidays • Agencies not involved in the assessment • Lack of clarity over contingency planning • Concerns that if the recent incident had not happened, this family would be currently 'hidden' due to the children being on school holidays	• Extended family were assessed and deemed to be supportive. • Recent re-referral has led this to being identified as needing support from CEFS • HV is now going to completed a RIC, look at impact of alcohol use and the impact of the mother's mental health on her children	

Case H

13 yr. old female – ongoing domestic abuse incidents but nothing recently to police.
Siblings in the family home – Child has lots of fallouts with school peers. Child has a disability
Known to Social Care on two occasions since 2006 on a CiN
Currently waiting for allocation to Cheshire East Family support

Overall Judgement on the Quality of the Work: **REQUIRES IMPROVEMENT**

What are we worried about?	What's going well?	What do we need to do?
• Housing state that there has been no bidding on properties	• Housing application was made in August 2017 • FACT 22 completed a report and evidence on	• SW's to be reminded to ensure that all assessment tools etc. are put in documents on

• Assessment on two of six siblings, differences presenting at school. Plan not as clear for this child, unsure of reason why • Recent incident of CSE being mentioned in relation to an image on Snapchat. Child denied this was her – no evidence to say it was her. • Initially agencies under confusion as to why this had been put on a CIN plan – it was found that this was directed by court – this is due to the child living with half siblings who are known to CSC. • Anonymous referral in June relating to children being left on their own – mother denied this	Liquid Logic of lots of work being done • Good communication between school health and Social Care • Good evidence of the voice of the child in school nurse assessment • School nurse observed child and this is documented in her assessment • Direct work undertaken with the child around online safety – CSE screening tool used	Liquid Logic meaning that these can be found easily

Please see the page below for the Full Audit Responses in Appendix B.

Appendix B: Audit Tool & Responses

When agencies are asked to complete a Multi-Agency Audit – they are requested to answer Yes/No to a series of question that reflect the following:

Quality of the Recognition – (R)
Quality of the Assessment – (A)
Quality of the Planning and Intervention (P)
Quality of Co-operation (C)
Quality of the Impact (I)

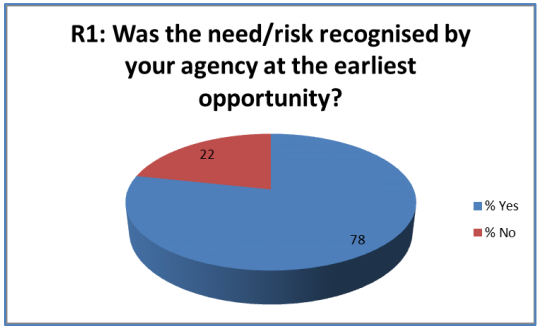
Examples of two of the questions are set out below. Each agency is requested to audit their own practice and then reflect on overall effectiveness for the child. As well as answering 'Yes' or 'No', some agencies have responded with 'Partly'. They are then requested to provide narrative to further illustrate their findings and to inform discussions within the multi-agency audit meeting. This narrative is completed in line with the Signs of Safety implementation throughout Cheshire East.

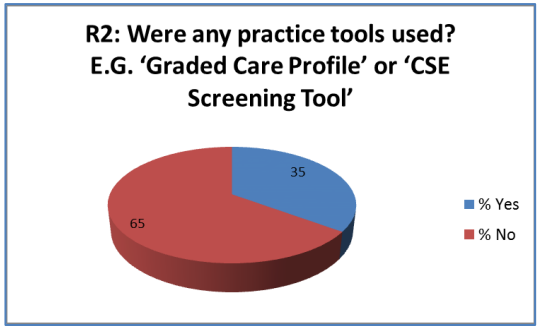
No.	Question	Response (Yes/No)	Comments on Quality of Work		
			What went well?	What are we worried about?	What needs to happen? (Any actions)
R1	Was the neglect recognised by your agency at the earliest opportunity? (If yes, how was this recognised?)				
R2	Were any practice tools used? E.G. 'Graded Care Profile' or 'Neglect Screening Tool' (If so, whom by and what was the outcome identified for the child at this stage?)				

When the audit responses are returned, the data is then analysed and graphical responses are created to evidence the full responses on all cases – this illustrates clearly how multiple agencies are auditing their own work, any patterns or differences in opinions. This data also helps to inform the recommendations being identified by the multi-agency audit group (as set out in page 7 of this report)

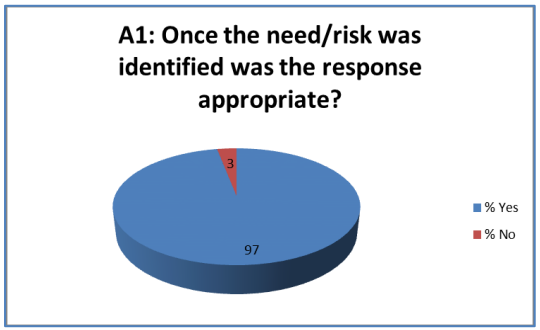
Below is a set of Pie Charts that illustrate responses to each question.

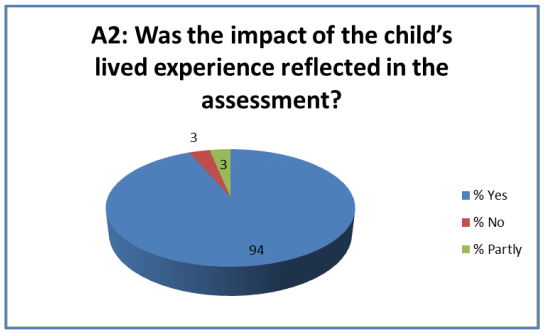
Quality of the Recognition – (R)

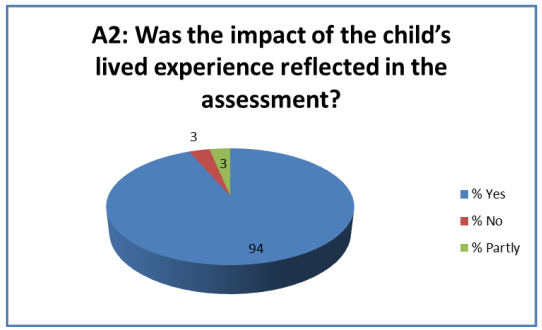


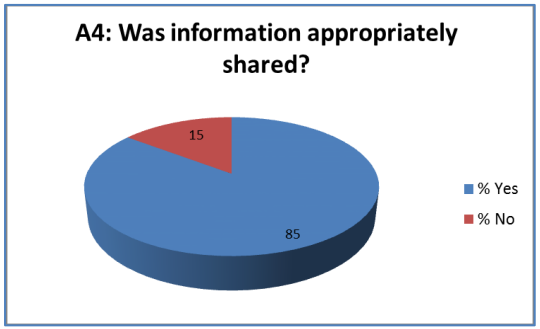


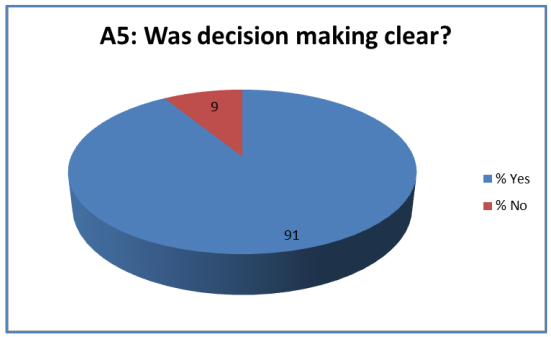
Quality of the Assessment – (A)

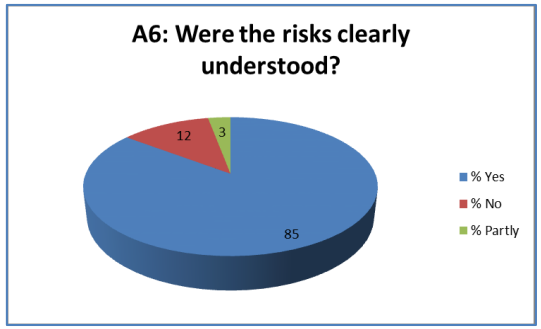


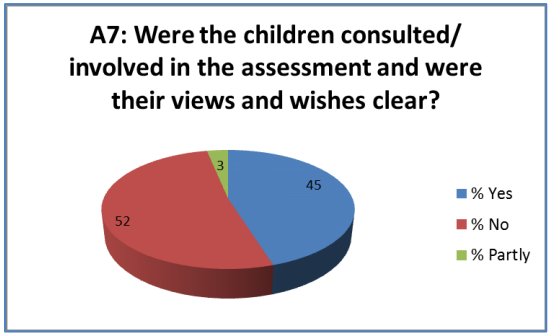


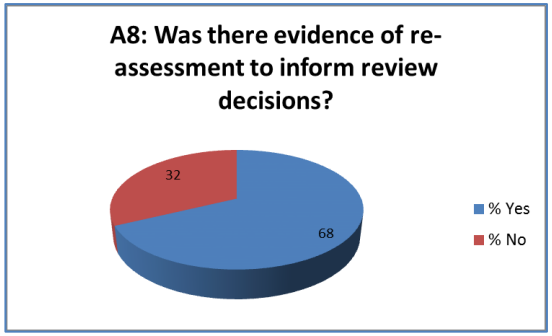




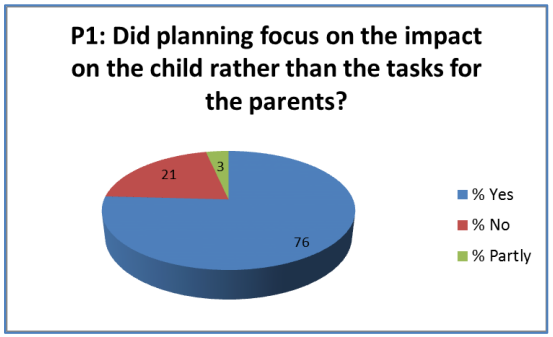


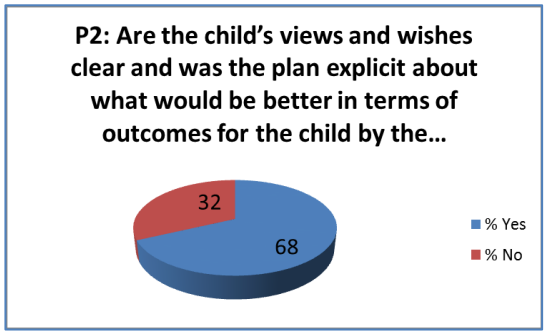


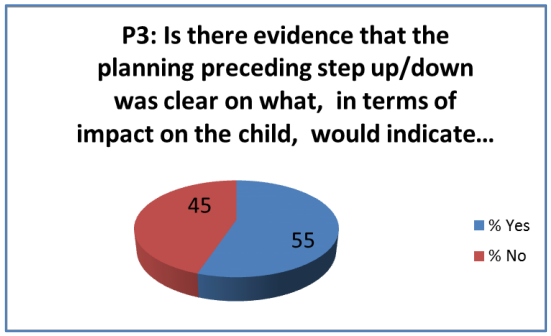


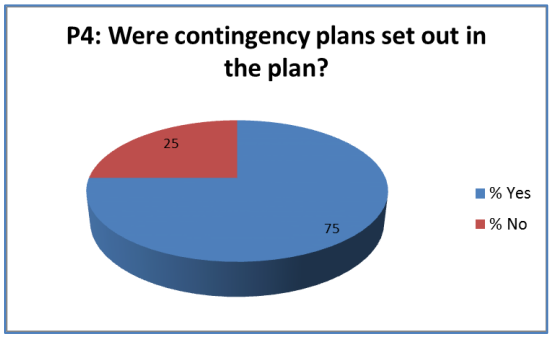


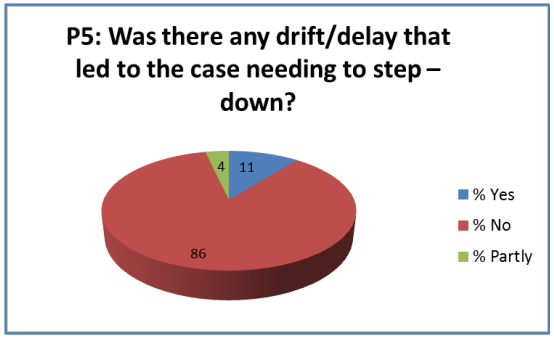
Quality of the Planning and Intervention - (P)

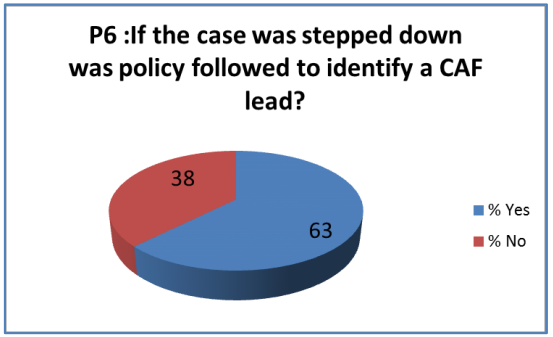


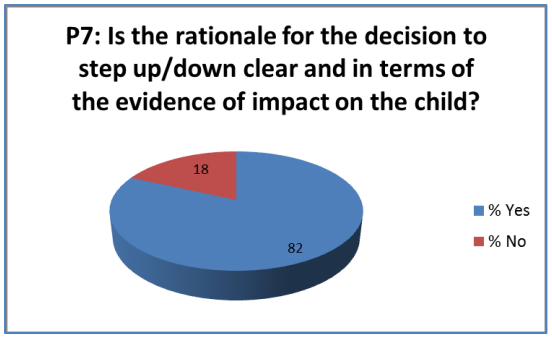




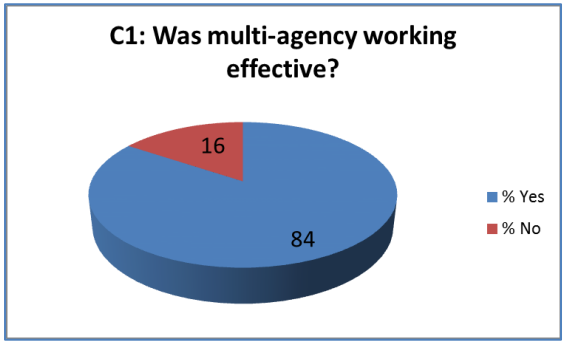


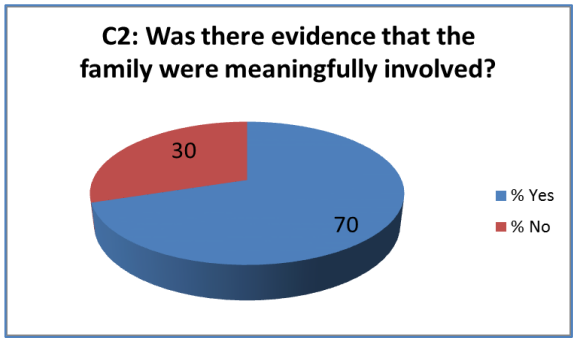


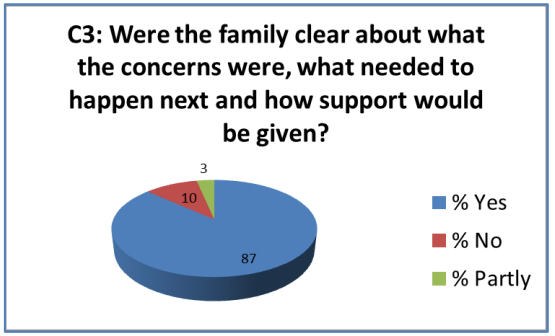


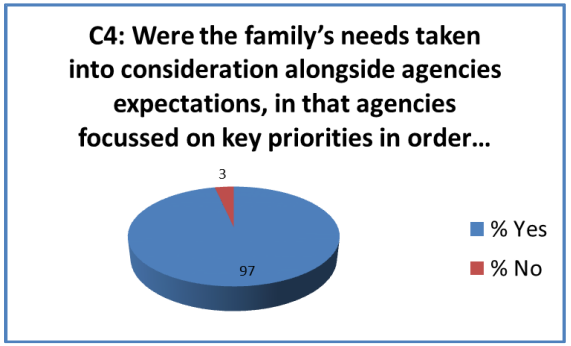


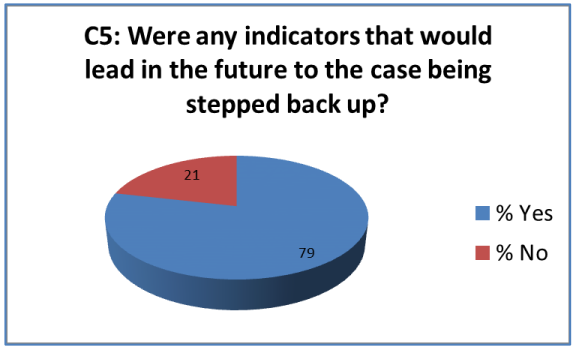
Quality of Co-operation - (C)

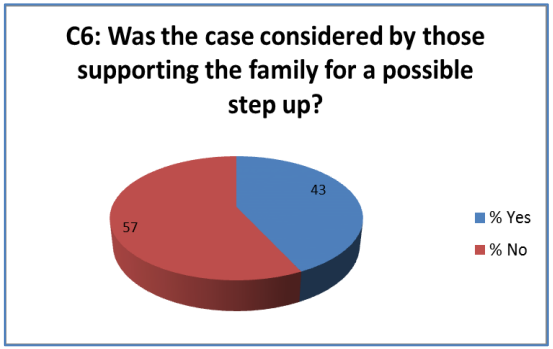


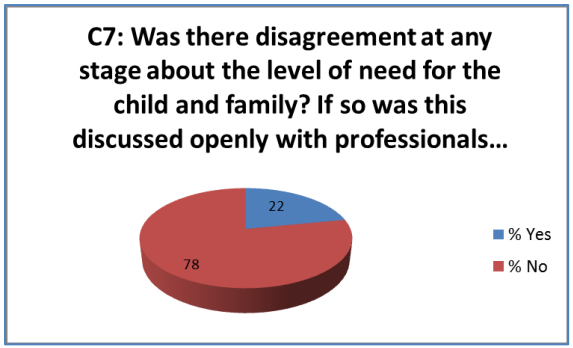




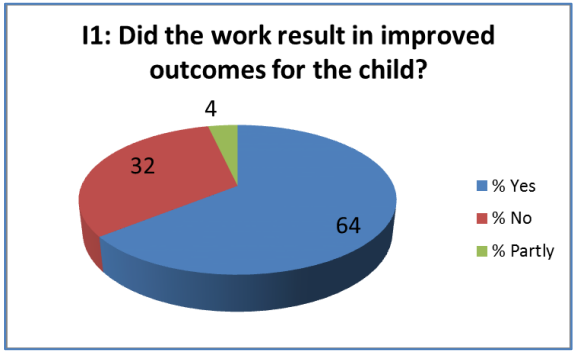


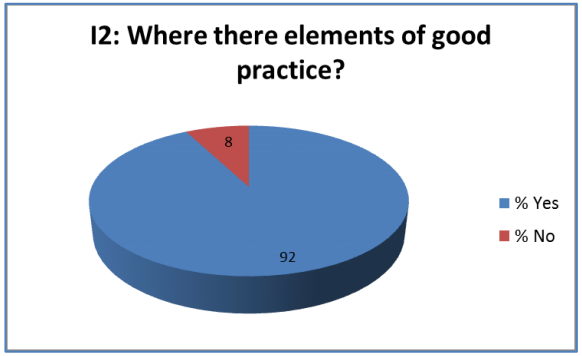


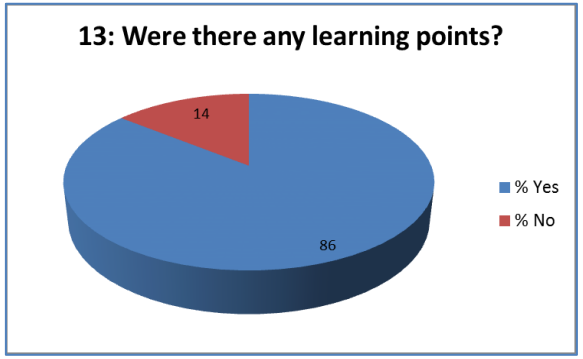




Quality of the Impact - (I)







Click on the Icon below to see the full audit tool used

1b. Step up Step down Audit Tool July