Brent	**Children and Young People Overview and Scrutiny Committee** March 2014 **Report from the Acting Director of Children and Families**
	Wards Affected: ALL
Audits by the Local Safeguarding Children's Board	

1. Summary

1.1 This report provides information about the:

- Statutory responsibilities of the Local Safeguarding Children Board (LSCB) to quality assure the work in the borough to safeguard all children through the work of partner agencies.
- An overview of the types and methods of quality assurance work that is undertaken and the outcomes of this work for the year 2013/14.
- Descriptions of the outcomes and actions completed following audits that have been undertaken.

2. Recommendations

2.1. The Committee are asked to note and discuss the content of this report.

3. Detail

3.1. In monitoring effectiveness, the LSCB aims to support and enable partner organisations to adapt their practice to become more effective in safeguarding children. The role of the LSCB is vital in determining the attitude of agencies towards improving practice on a multi-agency basis.

3.2. Effective partnership working through the LSCB aims to ensure a robust and systematic approach to quality assurance and a cycle of continuous learning through constructive challenge and will establish a culture that should filter through to all practitioners.

3.3. Multi-agency audits should be solution-focused and conducted in a non-judgemental and open environment of learning with the intention of further improving outcomes for children.

3.4. Working Together to Safeguard Children, with effect from 15th April 2013, provides a guide to interagency working to safeguarding and promote the welfare of children under Sections 11 (4) and Section 10 of the Children Act 2004. The guidance reinforces the duty of Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services and legislative requirements.

3.5. Brent LSCB has a self assessment audit tool in place to ascertain compliance in meeting safeguarding standards for the organisations listed under Section 11 of the Children Act 2004. Section 11 audits are also required for voluntary and community sector organisations commissioned to undertake pieces of work for partner organisations of the LSCB.

3.6. The quality assurance sub group of the LSCB has the delegated responsibility to commission, oversee and implement recommendations from multi agency audits, audits emerging from serious case reviews, management reviews from local or national issues where necessary and the implementation of actions from findings.

3.7. The sub group works to the Brent LSCB Quality Assurance Timetable 2013-2014 with key identified dimensions. The chair of this sub group is the Operational Director of Children and Families with other members drawn from partner agencies. The sub group meets monthly.

Dimension 1 - Effective organisational practice to safeguard and promote the welfare of children

3.8. The LSCB has a key role in achieving high standards in safeguarding and promoting the welfare of children, not just by coordinating multi agency work, but also by evaluation and continuous improvement. In Dimension 1 each individual organisation is asked for a report to be provided about work that is completed in specific areas, to share the outcomes of inspections and finally to self-evaluate their service against an agreed Section 11 audit templates. The results are shared with the Board for consideration, challenge and advice on further actions**.**

3.9. The following areas of work therefore are incorporated into this dimension:

- Section 11 audits
- Outcomes of inspections
- Single Agency annual reports
- Local Authority Designated Officer (LADO) report
- Multi Agency Public Protection Arrangements (MAPPA)
- Multi Agency Risk Assessment Conferences (MARAC)

Section 11 Audits completed in 2013/14 Period

3.10. Section 11 audits in 2013/14 have been completed for the following service areas within the Brent Partnership; Community services, Housing Needs,

Adults Social Care, Children and Families, Met Police, NWLH NHS Trust, Brent CCG, London Probation Trust and Brent Youth Services. These section 11 audits have led to further actions required to ensure professionals have the right information, training and forums to safeguard children in the borough. To promote learning from the findings of both Brent and other boroughs Serious Case Reviews through multi agency learning events. These are delivered by the LSCB Training Coordinator.

Dimension 2 - Effective multi agency practices to safeguard and promote the welfare of children.

3.11. The LSCB is responsible for ensuring that effective multi-agency practices are undertaken to safeguard and promote the welfare of children. Multi agency practices refers to service provision from a multi agency perspective at the point of delivery to service users, the expertise by which these are delivered, the timeliness of the initial contact, the final outcome and the experience of the user. The audits of practice will often result in shared learning and further development of partnership work on the ground for agencies. The LSCB use audits and an agreed detailed data set of the performance of services to children to gather information about how operational delivery is working. Areas of themed audits are identified where there maybe a particular issue, an issue of national interest or where we have a statutory obligation to complete a review such as in the case of a Serious Case Review. SCRs provides an opportunity to look in extensive detail at partnership work and will always result in an action plan for learning and improvement.

The following areas of work are therefore incorporated in this dimension.

- LSCB Dataset
- Multi agency audits commissioned by the LSCB which include;
  - Themed case audits
  - Case Studies
  - Reflective practice reviews
- Serious Case Reviews
- Management reviews

Dimension 3 - **The effectiveness of Brent LSCB to safeguard and promote the welfare of children**

3.12. The LSCB's primary function is to bring together representatives from agencies and professionals responsible for safeguarding children. It is an inter-agency forum that agrees how the different agencies and services should co-operate to safeguard children in the area and make sure that arrangements work effectively to bring about good outcomes for all children and so it is important for the LSCB to measure how effective the board is at doing this work**.**

3.13. In July 2013 the LSCB has undertaken a self evaluation of effectiveness of the board against an agreed template that considered how well the partnership was working The findings from this were used at the annual Business Planning Day to consider further developments.

3.14. In addition the Chair of the LSCB is appraised annually by the Chief Executive to ensure personal effectiveness of the Chair.

3.15. The following areas of work are therefore incorporated into this dimension:

- Brent LSCB audit tool.
- Chair of LSCB annual 360 degree evaluation.

3.16. In the period 2013/14 a reorganisation of the LSCB sub groups led to fewer multi agency audits being completed. A full programme has been re-established for the latter part of 2013/14 and the 2014/15 period under the new structure.

3.17. The LSCB quality assurance work takes place alongside any individual agency's quality assurance mechanism.

3.18. Brent Children and Families have an independent quality assurance policy containing guidance and a programme with a calendar of audits undertaken on a routine and regular basis.

Multi agency audits undertaken 2013/14

Title of audit: Section 47 strategy meetings/discussions

3.19. In July 2013, following a serious case review (SCR) a further audit was undertaken to look in greater detail at the involvement of professionals in strategy meetings/discussions and the accurate recording of notes of those meetings on the child's record.

3.20. The findings; the majority of the 19 cases audited resulted in a 'good' or 'outstanding' outcome in multi agency cooperation in strategy meetings.

3.21. Outcome; to repeat the audit in six months. To develop standards for partner agency attendance at Section 47 strategy meetings. The attendance of professionals at meetings is greatly assisted by the operation of a MASH where all professionals are available in one place and a list of health professionals who are not readily available has been widely circulated. There has been a marked increased in health representatives who are not co-located, in their attendance at strategy meetings.

Title of audit-Family Engagement Audit - Engagement with Fathers/partners in the assessment process by all agencies

3.22. In September 2013 this audit was undertaken as a result of the Ofsted Safeguarding Inspection recommendations and an SCR. This audit closely examined a small number of cases to establish whether all agencies were appropriately involving the relevant and necessary family members.

3.23. During the course of this audit the scope broadened to include other very significant family members that could have otherwise been overlooked (for example grandparents and older siblings). Four cases were selected randomly.

3.24. The Findings; Most cases showed agencies worked collaboratively to involve appropriate family members and appropriate challenges were made where there was non engagement by Parents or family members or lack of information sharing by family members. On occasion, professionals were

hampered by family members not sharing information with professionals which was not acted upon.

3.25. Outcome; the increased use of Family Group Conferences would assist in the identification and involvement of family members. That all professionals must share all information at the earliest point in an assessment. The need for a Family Group Conference is a standing item for discussion during all child protection conferences.

3.26. This audit will be repeated in the 2013/14 period and will look in detail at cases of neglect.

Title of audit -The Journey of the Child

3.27. In January 2014 a multi agency audit was completed focusing on the journey of one child with complex needs through service areas. This audit considered how effectively agencies were able to work together to meet the child's needs when the parents were hostile and uncooperative. Complex medical problems, Medical- Social Interface, expert opinions Hostile and complaining parents and Multi-agency working

3.28. The findings; Experts should be instructed using the Family Law expert framework. Parent's hostility could delay intervention and referral to court and have a detrimental impact on their child's wellbeing. Courts should be used earlier if parents do not co-operate with medical decision making that is in their children's best interest

3.29. Outcome; that medical experts should be linked with the local Designated Professionals. When presented with hostile parents professionals should always view this behaviour in terms of the impact on the child. All agencies should adopt a zero tolerance policy of violence and aggression towards staff. The impact of parents who do not engage with services must be kept under review during assessments and acted on if it is of detriment to the child via the legal route if necessary. Cooperation is discussed at all child protection conferences and where there is no progress at a third review there is a meeting between the Principal Officers to address why this is and decide on actions to progress should take place

Title of Audit Information sharing for Child Protection Lists

3.30. In Oct 2013 a re-audit was completed of information sharing amongst health professionals.

3.31. Findings; since the first audit all health providers receive the lists of children on Child Protection Plans via a secure email address, weekly. New personnel are added to the circulation list. A flag is added to the child's name on the electronic record when they are on a child protection plan which notifies health staff that may come into contact with the child.

3.32. Outcome; to ensure the recipients are correct, the contacts for receiving the lists should be checked regularly by social care/CCG. A single point of contact should be considered.

Serious Case Reviews

3.33. In the 2013/14 period two serious case reviews have been completed. Both of these SCRs looked in detail at very serious incidents involving children and resulted in learning for Children and Families Service and partner agencies in areas of training of staff, collection and managing of information, organisation of systems and delivery of services to adults who are parents.

4. Financial Implications

4.1 There are no financial implications contained within this report.

5. Legal Implications

5.1 Legal comments are contained in the body of the report.

6. Diversity Implications

6.1 Equalities considerations are important throughout the work of the LSCB and particularly in its approach to quality assurance. No particular issues around, for example, cultural relevance of services, are picked out in the particular audits referred to in this report but it is certainly part of the considerations and review formats.

7. Anti-poverty implications

7.1 Brent has high levels of social deprivation and this has to be taken into account in safeguarding children since they are more vulnerable where there is high mobility and where housing conditions are poor.

8. Staffing/Accommodation Implications (if appropriate)

8.1 There are no Staffing or accommodation implications contained within this report.

9. Background Papers

9.1 None

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