# GSCP CONTACTS TO MASH AUDIT

*2021*

"Despite COVID-19, the MASH continues to provide a timely and proportionate response to children and families at the first point of contact. However, the comparatively high rate of referrals to Children's social care suggests a degree of risk aversion and/or a failure on the part of partner agencies to fully understand or consistently apply thresholds." Ofsted (2020)

This audit seeks to provide assurances and a response to the Ofsted question posed in 2020

# Gloucestershire Safeguarding Children Partnership

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire
COUNTY COUNCIL

## Contents

## Introduction

The Partnership wants assurance of robust recognition in response to the Ofsted (2020) visit which highlighted "despite COVID-19, the MASH continues to provide a timely and proportionate response to children and families at the first point of contact. However, the comparatively high rate of referrals to Children's social care suggests a degree of risk aversion and/or a failure on the part of partner agencies to fully understand or consistently apply thresholds." Throughout the report; the phrase contacts into MASH will be used to align with Ofsted's statement as well as ensuring all audiences understand the subject matter. MASH will also be the phrase used when referring to a MARF/notification into Children's Social Services. The MASH multi-agency audit was completed reviewing all notifications assessed over a one month period regardless of whether referral resulted in assessment by MASH, Early help or deemed no further action (NFA).

The multi-agency audit reviewed the decision making made by Partner agencies into MASH. All outcomes of notifications were reviewed including (but not an exhaustive list) NFA, strategy discussion and referral to early help. The sample used was covering a one month period from 8th March 2021 to 8th April 2021, this time period coincided when school's reopened after the first lockdown in 2021. Notifications into MASH were reviewed from the following agencies; Constabulary, Education and Health. A random sample of 20% of the activity over the period identified was audited, this equated to 111 notifications. These children/young person notifications were randomly allocated to each group. Each group had representation from all Partner agencies with Children's Social services to support navigation of the IT system. The groups audited 22 notifications with one auditing 23.

The groups were provided with an audit template, consisting of eleven questions aimed at answering Ofsted's questions:

1) Is there a degree of risk aversion within Partner Agencies?
2) Is there a failure on the part of Partner Agencies to fully understand or consistently apply threshold?

The groups were given two weeks to complete their audit sample. 105 notifications into MASH were audited; reasons for incompletion were a locked case, the young person was already a child looked after and duplication of notifications. 36 young person notifications were referred from Education settings, 37 from Health settings and 32 from the Constabulary.

This report will provide key observations amongst all Partner agencies, followed by a multi-agency analysis of the audit findings for each Partner agency. Concluding with a summary answering Ofsted's questions listed above. Lastly recommendations will be suggested which have been consulted and agreed with Partner agency colleagues.

Recognition and thanks is to be given to all multi-agency auditors who fully committed to the audit process; were keen to collaborate and specifically adhering to the tight timeframe to which the audit was completed. All audit groups completed and submitted their audit results within the two week period. Thank you to everyone involved.

## Key Observations:

Children and young people present physically and emotionally to the Safeguarding system differently, either whilst in education; an admission into the Health economy or during a Police incident. In the school environment teachers/other staff members are likely to have regular contact with children/young people and will therefore be able to detect a change in emotional status. They have the time to build up trust and develop a relationship with a child/young person. In comparison Health and Constabulary encounter the child/young person and their families on occasion, in a heightened emotional state and colleagues are required to build trust rapidly. Due to these variables this impacts on the amount of context submitted to MASH.

The Health economy contains multiple individual sectors with many more referral sources including for example; NHS 111, Health visitors, community nurses, SWAST and GP's to name but a few. Different sectors within Health have varying time and access to children. For instance a Health Visitor or school nurse potentially may have greater opportunity to see a child/young person more frequently and also have access to more in depth child and family health records. Therefore may be able to provide greater quality and more sufficient information when submitting a notification into MASH. Compared to NHS 111 or SWAST who encounter a child or young person during that one incident when their services were required.

When Constabulary colleagues create a UNIFI Enquiry an automatic referral form is created which goes to CSC. This form acts as a MARF for the Police and this referral form and mechanism into MASH has been agreed with CSC pre 2017. The VIST was developed as a risk assessment tool in 2017 to act as an internal referral form, replacing the DASH, CP referral form and AAR referral form; this is sent to CSC as an additional document. It is an internal Gloucestershire Constabulary document and does not act as the MARF. The Police also notify MASH of children/young people who have had a missing episode using a Compact missing notification.

Health with its multiple sectors advocate the use of the MARF but there is awareness that NHS 111 and SWAST notify MASH using an adapted MARF. Education predominantly uses the MARF form.

### Recommendation:

- A review of the MARF process to consider adopting a process that focuses on quality driven submission rather than a process driven submission
- Review of Partnership agreement for Partner agencies to adapted risk assessments to meet their support models and focus on quality of information rather than an adherence to process.

Partner agencies completed the audit with the perspective of answering Ofsted's questions; whether Partner agencies are 1) risk averse and 2) is there a failure on the part of partner agencies to agree thresholds.

## Are Partner agencies risk averse?

The audit reviewed the decision making by Partner agencies into MASH. Therefore the outcomes of the sample included; not followed up (NFA), strategy discussion etc. To answer Ofsted's question of

whether the Partner agencies are risk averse, one would recommended a review of the audit sample to understand how many of the 105 notifications concluded NFA.

**Recommendation:**

- A review of audit sample to understand the percentage of notifications concluded NFA including the reasons for why they concluded with NFA.

The audit questions teased out whether a risk averse approach is being taken amongst Partner agency colleagues. If these are reviewed as a whole they can help answer whether Partner agencies are risk averse. A sample of questions will now be explored; when the findings are combined it will help to answer Ofsted's first question.

Fig 1:1 explores whether opportunities were taken for extra support prior to the notification into MASH. It suggests that all Partner agencies to an extent engaged with the child/young person and their families/guardians to provide extra support. Education and Health have a higher proportion of their notifications where there were no opportunities for extra support and note that 50% of the Police samples were not applicable to this question. Examples of extra support include; modified timetables, Teen in Crisis support, CAMHS support and MyPlan+. Fig 1:1 demonstrates opportunities for extra support were not consistently taken or considered and therefore suggests a degree of risk aversion.

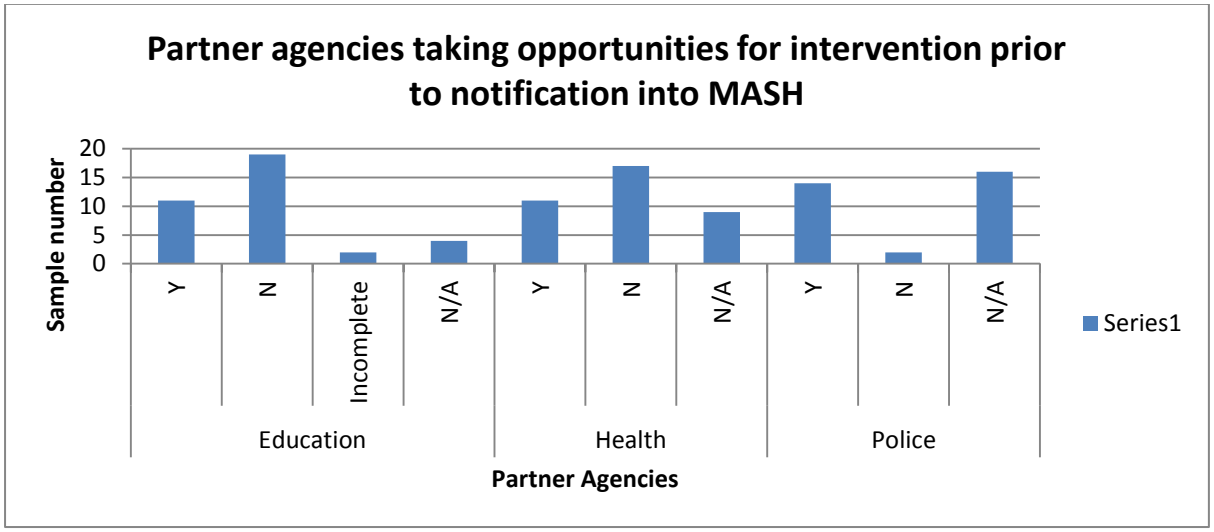


Fig 1.1

Once a safeguarding risk has been identified a timely notification should be submitted. There are a plethora of reasons for delay in submitting a notification such as organisational demands, staff capacity, and lack of understanding or access to referral mechanisms. The majority of notifications were submitted in a reasonable timeframe. Health had the most delayed notifications into MASH, auditor narrative regarding a delay suggests reasons for this:

1. Health colleagues assuming a parent is present and able to provide care
2. Organisational pressures; MDT review of admissions ensure reflective practice when at the time of admission, patient demand outweighed staffing capacity.

3. Parents/guardians providing misleading information.

A delay in notification once the risk presented would not suggest a degree of risk aversion but a greater understanding of the stresses Partner agencies are under which cause a delay would be beneficial.

**Recommendation:**

- Further exploration into reasons for delay and a better understanding of the complexities of the Health system.

To help answer if Partner agencies are risk averse one can review whether the notification into MASH was due to the child/young person safeguarding need or due to organisational process. Fig 1:2 demonstrates the vast majority of notifications into MASH were sent due to an identified need. Health and Police colleagues submitted more notifications without an identified need. In both organisations there is a mindfulness of safeguarding concerns, an example is Police notify MASH every time a child/young person is missing. This is an accepted practice and therefore should there be leniency for incidences of normal concern to follow a process?

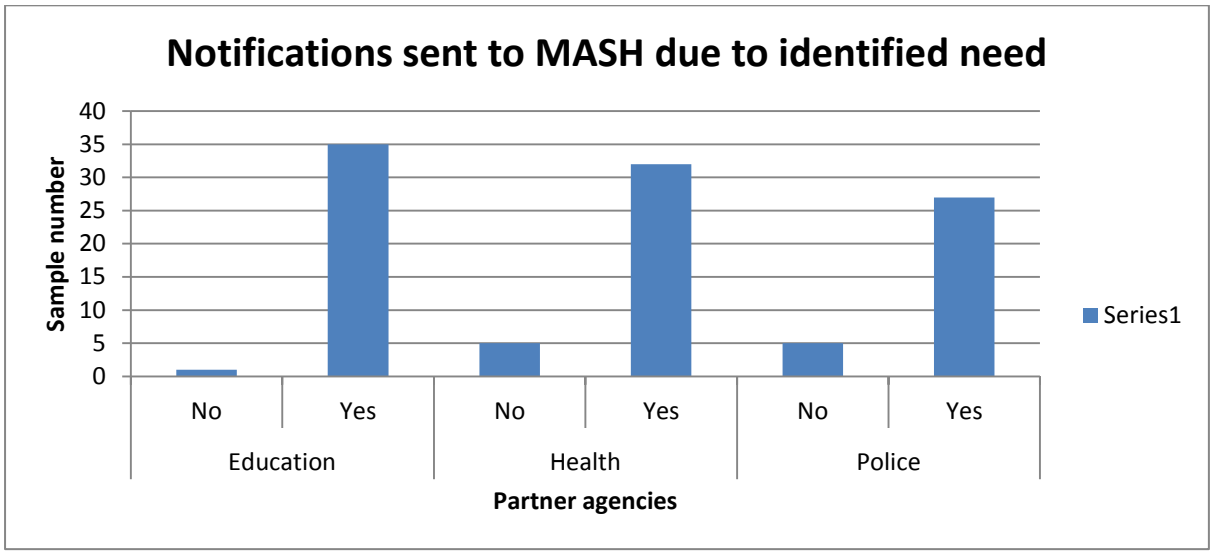


Fig 1:2

## Is there a failure on the part of Partner Agencies to fully understand or consistently apply threshold?

Providing sufficient quality information to identify level of intervention (LOI) was consistently not applied amongst Partner agencies. 81% of Education's notifications had sufficient quality information to identify level of intervention; 84% of Police notifications and 65% of Health's notifications had sufficient information.

To support Partner agencies to identify threshold they are encouraged to use Partnership agreed toolkits to supplement their notification in MASH. A Partnership agreed toolkit is in relation to the pre-birth and neglect toolkit amongst others. There is limited evidence of Partner agencies using a toolkit to accompany the notification into MASH. Fig 1:3 demonstrates the Partner agencies use of agreed toolkits to supplement the MARF. As previously stated the Police have an agreement that

the VIST is used to provide additional information. Therefore the Police data has not been included. The limited use of toolkits reduces the Partnerships ability to evidence their concerns of significant harm for the child – and thus impacting on showing application to thresholds.

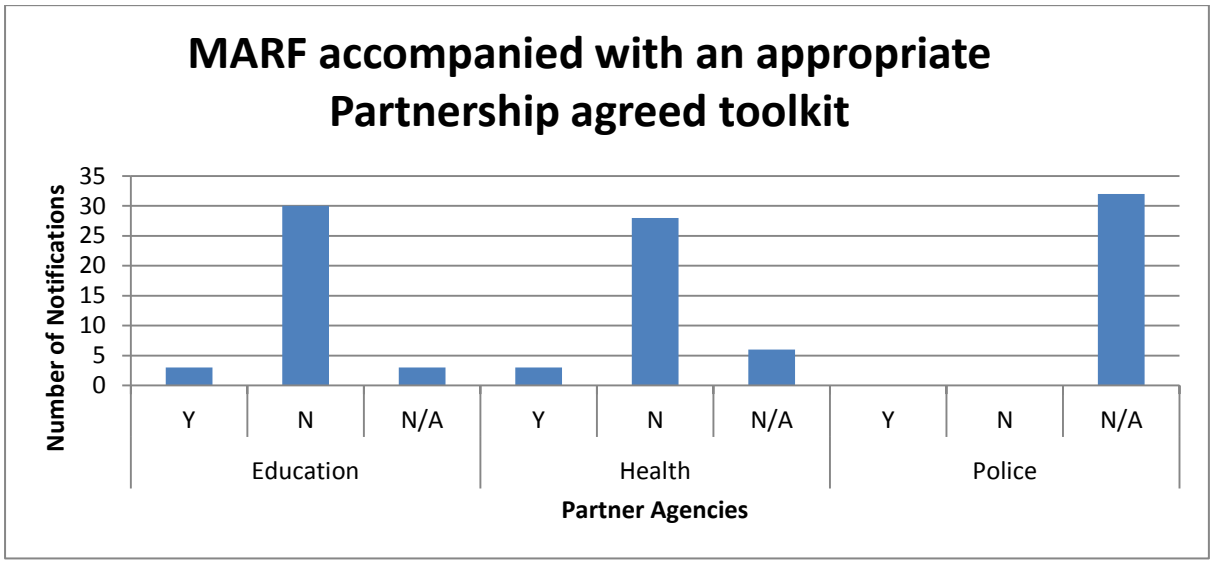


Fig 1:3

The notifications into MASH suggested a number of children or young people did not receive any Early help activity, which Fig 1:4 demonstrates. The data suggests Health and Education colleagues have more access to the early help provisions that are available, and are more able to trigger the early help pathway. Education professionals have an understanding of the Early Help offer that has grown in recent years. Education colleagues are possibly in a better position to access early help support, due to the amount of contact they have with the child and family. Police, feel it is reasonable that they do not have an insight into whether a child has MyPlan etc. but have made assurance their frontline colleagues would be made aware if a child was in care.

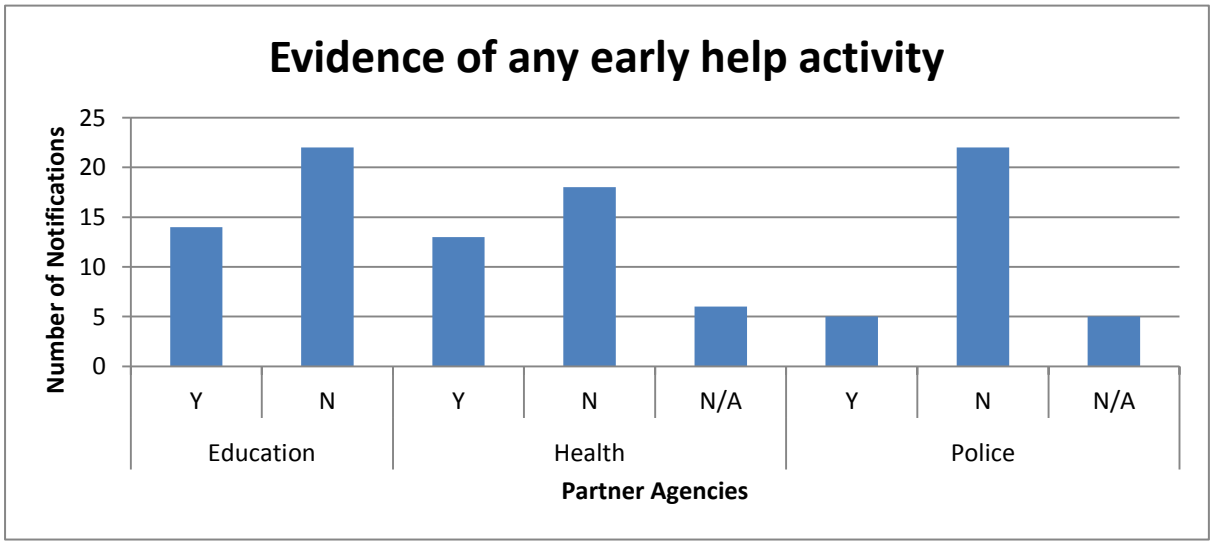


Fig 1:4

## Education Key Headlines:

The Education sector submits notifications into MASH the vast majority via the Portal. The auditors found they completed notifications to a higher quality compared to other Partner agencies. This to some degree is not surprising taking into account the amount of time Education colleagues spend with children and their families. Education predominantly completed notifications into MASH using the Portal and by completing a MARF compared to other Partner agencies. 100% of their notifications contained appropriate identifiable contact details. 69% of notifications evidenced engagement with the child/parent or guardian and consent was gained. Of the remaining 31% of notifications that did not seek consent, only 3% which equates to 1 notification from education should have engaged with the child and family. The other notifications where consent was not gained had valid reasons for not obtaining consent.

### Is the Education Sector Risk averse?

As previously stated it would be helpful to understand how many of the notifications audited had an outcome of 'no further action' to fully answer this question. However 89% of child/young person notifications were submitted in a timely fashion once risk was identified as determined by the auditors. The SWCPP guidelines state Partner agencies should respond to abuse and neglect within one working day of identification or disclosure of harm or risk of harm. 94% of notifications were submitted due to an identified safeguarding need, with 3% being submitted due to organisational process. The majority of notifications into MASH did not provide any information of the child or young person receiving any Early Help intervention. Auditor comments on the 31% of notifications which evidenced early help interventions prior to the notification provide further context on this topic:

- One child/young person had been previously supported by early help with outcomes met but re-referral then received
- One child/young person had a MyPlan+ which was held in the community with previous Child protection plan and Child in Need Plan.
- Education colleagues had difficulties family/guardian members not engaging.

### Is there a failure on the Education sector to fully understand or consistently apply threshold?

81% of Education notifications contained sufficient quality information in order to identify level of threshold and threshold was applied appropriately. The vast majority of notifications did not include a Partnership agreed toolkit, with only 8% of the sample responding a toolkit was not applicable. The neglect toolkit was the only toolkit used to supplement the MARF.

### Education Summary:

There were clearly some very good young person notifications into MASH with the auditors commenting:

- Appropriate early intervention attempted and referral following non compliance
- An immediate concern was raised and agreed an immediate response was required.
- It is clear the child has a good relationship with the school

- Referral was to the point and clearly identified risk of harm

Education colleagues utilise resources appropriately – they submit a MARF into MASH and if there is an immediate risk to a child/young person, a call is made to MASH for urgent support; as a consequence more information and context was provided. Education have more of an awareness regarding early help activity, this is unsurprising taking into account colleagues see children/young people in their environment more frequently. Since completing the audit Education colleagues have reviewed the audit results and have taken the following actions; exemplifying what a good MARF process looks like is being produced. Education colleagues have also delivered a webinar to schools and Early Year settings on what a good MARF looks like.

## Health Economy Key Headlines:

The Health economy has multiple sectors. There is an acceptance by Health colleagues that some sectors will provide limited information into MASH due to the level of contact they have with the child and family. There is a clear distinction between Health colleagues who have an intimate knowledge of the child such as Health Visitors compared to NHS 111 who have sporadic contact and therefore limited contextual information. To note the agreement and arrangement with police is not reflected with elements of Health economy that has a similar light touch contact with children. Health colleagues advocate the use of the MARF however the audit demonstrated frontline staff use a variety of methods to submit a notification including; phone, email, MARF, SWAST or NHS forms. Only 51% of notifications used a multi-agency referral form and thus sufficient, quality information was lacking including poor record keeping of contact details and consent not being sought prior to notification to MASH. The majority of notifications evidenced engagement with the young person or family to gain consent. 11% of notifications had a valid reason for why engagement/consent was not sought. The areas within the NHS where consent/engagement was not sought without a valid reason are NHS 111, Community, ED, GP and SWAST.

### Is the Health Sector Risk averse?

In relation to Health submitting notifications into MASH, one needs to consider the ages and context in relation to the safeguarding risk. For example children have accidents as part of their developmental journey. Therefore it is professional judgement to determine whether the child/young person has sustained an accident or whether a safeguarding incident has occurred. This debate brings a certain degree of anxiety. This anxiety is demonstrated with 86% of notifications being submitted due to child/young persons need with 14% being due to organisational process. Health has a safety loop in place to review child/young person attendances within a short timeframe after the child has presented. This is demonstrated in the audit where 33% of notifications were delayed once the risk was identified. 49% of notifications did not evidence whether any early help activity had been involved with the young person or family, suggesting whether the notification was needed or whether early help interventions would have been an acceptable first course of action.

### Is there a failure on the Health sector to fully understand or consistently apply threshold?

65% of notifications provided sufficient quality information to identify level of threshold which was appropriately applied. This statement aligns with 76% of Health notifications did not have a relevant Partnership Agreed toolkit to supplement the referral form. This would indicate the Health economy cannot consistently apply thresholds, however there is debate regarding the appropriateness of the level of knowledge the varying sectors have.

### Health Summary:

The Health economy is complex and sectors should be assessed differently according to their level of contact with the child/young person, the Partnership should reflect on the appropriateness of this. A number of notifications were delayed once risk had been identified. Health colleagues are not consistently using Partnership agreed toolkits, which does not provide confidence that the Health economy consistently applies LOI.

### Health Recommendations:

- Advise on the sectors within their economy that will have varying knowledge of the child and family to ascertain which sectors have the ability to include quality information compared to sectors that have fast contact and therefore limited information.
- Understand the usability of toolkits
- Further review of Health audit sample to extrapolate further information and context.
- Should health provide an interim triage support for notifications to be reviewed prior to assessment by MASH?

## Constabulary Key Headlines:

The Constabulary have adapted their organisational process to adhere to safeguarding advice in collaboration with the Partnership. Frontline staff use handheld devices to complete a VIST or Compact missing notification which encompass their safeguarding forms. These forms are being adapted but the adaptation to reflect all toolkits and screening tools are not complete due to lead times on digital process changes. Police colleagues have questioned the suitability of some of the audit questions as in their field the level of background context can be limiting due to the brief contact they have with the child/young person, thus at times it is difficult to ascertain LOI. Police use the VIST as a mechanism to refer to Early Help or raise safeguarding concerns. Police colleagues determined they would be able to ascertain whether a child is a Child Looked After; however they have provided assurance that a VIST would be submitted for any level of vulnerability.

In 75% of notifications there was evidence the child/young person or parents/guardian were engaged with the notification and consent sought. Of the remaining 25%, 3% which equates to one notification, consent should have been sought. On reflection as this represents one case it may be due to an officer requiring additional training. The remaining notification, consent was overridden due to the significance of the incident. Police use Social Worker colleagues to aid them to engage and seek consent from parents or guardians regarding the notification into MASH.

Police colleagues have two main questions of this audit:

- Have the VISTS been submitted at the correct risk level?
- In the detail of the VIST should the notification have been submitted in the first instance?

These two questions from a Police perspective would answer Ofsted's question regarding risk aversion and ability to apply threshold consistently.

Regarding the sharing of information between Partner agencies; a question has been raised once a missing notification has been submitted are CSC automatically notified by email? Once the child/young person is found is a further notification automatically sent? If this is the case Police recommended an automated missing notification is sent to a generic Health email address.

## Is the Constabulary Risk averse?

As with the other agencies it would be useful to have an understanding of the notifications that were audited that received the outcome NFA to fully answer this question. It is advisable that a deeper review of the Police notifications is completed to have a better understanding as to whether the VISTS/Compact notifications that were submitted were reasonable in regards to the presented risk. The majority of notifications were submitted due to the child/young person's need, but 44% of notifications state there were opportunities for extra support. Dependent on the department completing the VIST, they may not have capacity to sign post or make an additional referral to Early Help.

## Is there a failure on the Constabulary to fully understand or consistently apply threshold?

A further analysis of the Constabulary notifications is advisable however auditors concluded 84% of Police notifications included sufficient information to determine level of intervention and was appropriately applied. Under half of the notifications included supplementary evidence in the form of a Partnership agreed toolkit. However the VIST notification form has been adapted (and will be adapted further) to include key information from the neglect and CCE/CSE toolkit. Police would like further collaboration into how elements of the pre-birth protocol can be incorporated.

## Constabulary Summary:

Police use VIST or Compact missing forms to notify MASH of a safeguarding incident. There is Partnership acceptance that Police can record safeguarding incidences differently from other Partner agencies. On review of the Police sample auditor's highlighted limited information was provided on the VIST/Compact form to identify level of threshold. There is already work in progress to add topics to the safeguarding forms that address the neglect toolkit, CSE/CCE and pre-birth protocol. Police have raised whether it is appropriate for frontline staff to have an awareness of early help activity in the context of their brief encounter with the child. Realistically a Police Officer should be aware of if the child/young person is a Child Looked After.

## Constabulary Recommendations:

- Review of automated emailing system for missing child/young adults to ensure Health is included.

- Deeper dive to ascertain whether notifications submitted were reasonable due to the presented risk.
- Collaboration with Partner agencies to adapt VIST to include pre-birth protocol questions.

## Audit Observations:

It is clear that children and their families present to the safeguarding system differently. The Health sector have multiple strands within their economy which have varying amounts of contact with children, should there be an acceptance that certain sectors have access to limited information? Education colleagues see the child/young person and family for over 100 days per year, so is it appropriate to expect Health and Police to have the same level of knowledge regarding the child/young person during a brief incident in their organisations? Should the Partnership be reflecting the agreement and arrangement with Police to elements of the Health economy that have a similar light touch contact with children?

1. Ofsted have suggested due to the volume of notifications that Partner Agencies are risk averse, this needs to be further explored through establishing how many of the sample resulted in NFA.
2. It is recognised by the Partnership and Ofsted that there is a level of activity being processed by MASH but the quality of information is missing, and it is this quality information that is required by MASH to allow critical thinking leading to an appropriate, well-informed decision.
3. Regarding whether there is a failure on the part of Partner agencies to agree thresholds, a clear observation is the Partner agencies are not utilising consistently Partnership agreed toolkits to substantiate the notifications into MASH. Education and Health colleagues have an awareness of early help pathways and thus greater access to early help activity but may not utilise these prior to notification into MASH.
4. Partner agencies do not consistently use the MARF to notify MASH of a safeguarding incident. If the multi-agency referral form was used more frequently it would help Partner agencies to clarify what level of intervention is required.
5. Regarding the completed MARF notifications the question; “What services has been provided?” was consistently left blank by all Partners. Is this an issue of the Partnership failing to agree thresholds or is it that the MARF is not suitable for all agencies to use, as it asks questions they will never be able to answer due to the level of involvement they have with the child.

**Key recommendations from Audit can be found in Appendix 1.**

## Conclusion:

To conclude the audit was derived on the premise that the differing elements of Partners have equal opportunity and prior knowledge of the child/young person to explore all safeguarding aspects to enable a quality contact into MASH, on this basis each contact was and is being compared in a like for like manner. The audit results have justified it is not appropriate to compare each agency against a gold standard of information gathering, because certain sectors in Health, Police and other Relevant Agencies do not have the mandate, time or ability to gain and hold this context. It is clear that as a Partnership we cannot take a 'one rule fits all' approach. It is suggested the Partnership's focus should be on improving quality notifications into MASH, taking into account Partner agencies ability to provide sufficient information relating to the amount of contact they have with the child/young person. The Child Safeguarding Practice Review Panel's Annual Report (2020) suggested the noncompliance in the use of multi-agency toolkits, amongst other factors, leads to poor information sharing and reduced critical thinking or understanding of risk; this in turn leads to a delay and poor decision making. Where a Partner or Relevant Agency has broader contact with children and families and can provide a wider familial context the audit has identified they are not using GSCP agreed multi-agency toolkits and in addition are not consistently using MARF to contact the MASH, the reasons behind non-compliance is in itself complex and not wholly known but needs to be addressed to improve risk management and partnership decision making.

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## Appendix 1

## Recommendations:

| | Recommendation | Partner Agency | Response | Target Date |
|---|---|---|---|---|
| 1. | A review of the audit sample to understand the percentage of notifications concluded NFA including the reasons for why they concluded with NFA. | GSCP | MASH Subgroup to Lead on activity | TBC |
| 2. | A review of the MARF to consider adopting a process that focuses on a quality of information driven submission rather than a process driven submission | GSCP | MASH Subgroup to Lead on activity | TBC |
| 3. | Review of Partnership approach to risk assessments and toolkits to focus on quality of information rather than an adherence to a given process. | GSCP | MASH Subgroup to Lead on activity | TBC |
| 5. | A review of how feedback is provided to referrers and its impact on improving future referrals to the MASH | GSCP | MASH Subgroup to Lead on activity | TBC |
| 6. | Further exploration into<br>1. identified delays in Health trusts submitting notifications<br>2. Improving MASH and wider partnership understanding of the complexities of the Health system.<br>3. Consider implementing pre Health Triage of referrals to MASH | Health | Strategic Health Group feeding into MASH Subgroup | TBC |
| 7. | Deeper dive in Police sample to ascertain whether notifications submitted were reasonable due to the presented risk | Police | MASH Subgroup to Lead on activity | TBC |
| 8. | Reviews of automated emailing system for missing to ensure all key partners, specifically Health are included. | Police | MASH Subgroup to Lead on activity | TBC |
| 9. | Collaboration with Partner agencies to adapt VIST to include pre-birth protocol questions. | Police | MASH Subgroup to Lead on activity | TBC |