16 December 2016

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Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in Wiltshire

Between 31 October and 4 November 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Wiltshire.[1] This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Wiltshire.

The inspectorates recognise the complexities for agencies in intervening in families where there is more than one victim and when, as a consequence, risk assessment and decision-making have a number of challenges, not least that the impact on the child is sometimes not immediately apparent. A multi-agency inspection of this area of practice is more likely to highlight some of the significant challenges to partnerships in improving practice. We anticipate that each of these joint targeted area inspections will identify learning for all agencies and will contribute to the debate about what 'good practice' looks like in relation to children living with domestic abuse. In a significant proportion of cases seen by inspectors, there were risk factors in addition to domestic abuse, which reflects the complexity of the work.

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Organisations across Wiltshire have worked together well to overcome issues that have been raised in inspections conducted by the different inspectorates over the last few years. These include children's social care, early help, police, health services, probation services, Cafcass, children's centres, youth offending services, housing, and child and adolescent mental health services, as well as voluntary and community services. Significant progress has been made in all areas to ensure that children and families receive a well-coordinated and helpful response when difficulties are identified. This is clearly evident in the work undertaken to support children who are experiencing domestic abuse. The areas for improvement identified are minor and will enhance changes already made. The challenge moving forward is to embed the improvements already achieved to maintain the momentum and pace of change to ensure a consistently strong approach.

Key strengths

- There is a strong and committed partnership across Wiltshire, including children's social care, police, health services (including child and adolescent mental health services and adult mental health services), probation services, Cafcass, children's centres, youth offending services and housing, as well as voluntary and community services, and this partnership has developed a culture of continuous improvement. All of these partners are dedicated to improving outcomes for vulnerable children, including those experiencing domestic abuse. It is clear that leaders in all organisations, including the lead member for children's services, the police and crime commissioner and the director of quality, Wiltshire Clinical Commissioning Group have prioritised the protection of children, including those living in homes where domestic abuse occurs.
- This relentless commitment to improvement has been particularly evident during this inspection within the Multi-Agency Safeguarding Hub (MASH). Developments led by the local authority have resulted in a service that is well resourced, well thought-out and represented by a wide range of appropriate agencies such as police, health, education and early help. More recent additions to the MASH, such as Child and Adolescent Mental Health Services (CAMHS), Splitz (the commissioned service for families experiencing domestic abuse) and housing, are creating an effective arena for information sharing and joint working. It is also positive to see the range of virtual partners, such as the National Probation Service (NPS), the Community Rehabilitation Company (CRC), the Youth Offending Service (YOS), adult mental health services and the army welfare service, who participate as required in the MASH. Information sharing within the MASH is appropriate, with consents obtained unless there is an immediate safeguarding concern. All staff spoken to are aware of their roles and responsibilities regarding consent and they adhere to guidelines. The analysis of risk is considered well and social workers, overseen by assistant team managers, make clear recommendations for referrals, immediate strategy discussions or signposting to other services. Referrals progress swiftly and delays are minimised.

Assistant team managers within the MASH have access to the diaries of duty workers in the assessment teams, and reduce delay by booking in first assessment visits.

- Leaders and managers across organisations have a good understanding of what is happening at the 'front door'. They use a variety of methods, including data analysis, audits, forums, performance meetings and seeking feedback from each other to ensure that their understanding is up to date. Data analysis is used as a starting point to develop hypotheses for further investigation. The approach of the partnership, which includes children's social care, police, health services, probation services, Cafcass, children's centres, youth offending services, housing, child and adolescent mental health services and adult mental health services, as well as voluntary and community services, is also reflected within individual agencies' internal oversight and audit processes and is leading to improvements within agencies. Managers use their knowledge to identify gaps and respond quickly. An example of this is the multi-agency audit of domestic abuse, which swiftly led to Splitz being represented in the MASH.
- In cases identified within the MASH as requiring an immediate strategy discussion, inspectors saw a swift and robust response. There is effective engagement in strategy discussions by a range of professionals based in the MASH, such as children's social care, police and health, while other partners, such as GPs, YOS, NPS, CRC and education staff, also contribute to meetings via a phone link. Actions arising are sent out to agencies very swiftly. Inspectors also saw evidence of timely strategy meetings taking place outside of office hours, such as a case on Sunday 30 October when a meeting was held involving the emergency duty team manager, a social worker, police and a consultant paediatrician. This allowed the case to be progressed in a timely way the following day. Single- and joint-agency child protection investigations are thorough, well recorded and contain clear decision-making.
- Audits of 10 cases are completed every week by the MASH senior manager, supported by senior representatives from police and health. These look at the work undertaken within the MASH. Cases are selected at random and the audits consider the quality of referral, appropriateness of threshold decisions, whether the rationale for actions is clear and whether management oversight leads to improved outcomes. Staff talked about how well feedback from these audits is managed, with a good balance struck between praising good practice while also addressing areas for development.
- A daily domestic abuse conference call (DACC) is held within the MASH to discuss domestic abuse cases that have arisen during the previous 24 hours. This is leading to improved information sharing, meaning that all agencies are aware of emerging risks in relation to domestic abuse. Consent is obtained before cases are discussed. The investment from the police in dealing with domestic abuse as a priority has meant that there is no backlog of cases waiting to be risk assessed,

so cases dealt with in the DACC are current, are prioritised and are allocated swiftly.

- The local authority has continued to improve the quality and consistency of core social work since their last inspection. Thus impacting positivelyon the quality of work undertaken to protect children at risk of domestic abuse. The majority of local authority work reviewed at this inspection demonstrated that the authority is undertaking good, child-focused, timely assessments that consider risk based on an understanding of the child's history. This then leads to effective planning, which safeguards and promotes children's welfare. In September of this year, the police force developed a tool to audit domestic abuse cases. Detective sergeants within the Domestic Abuse Investigation Teams are now required to conduct a monthly audit of six domestic abuse cases, with a view to ensuring that there is a consistent approach to dealing with domestic abuse across the force. While this is providing feedback, it is too early to measure the impact of the audit on improving outcomes for victims.
- Managers across children's social care, police, health services and probation services demonstrate effective challenge of each other when issues arise. This is seen as an effective way of ensuring that improvements are made, which have a positive impact. An example has been the challenge from the youth offending service and community safety to the criminalisation of young people with antisocial behaviour, to ensure that they are seen as victims when appropriate and ensuring that less punitive interventions are made available to them.
- Management oversight is clear and evident in children's social care. The core business of protecting children is done well and the quality of direct work was good in the majority of the cases seen, meaning that most children have positive experiences of interventions. The police have recognised the importance of frontline supervision when dealing with incidents of domestic abuse. For example, an officer can no longer submit a referral to the MASH following their attendance at an incident unless it has received supervisory oversight and has been signed by the supervisor. The police manager within the MASH reports that 99% of referrals are now signed upon receipt. Those that are not signed are returned but, importantly, this does not prevent MASH staff from sharing the information with partners in a timely manner. This is leading to an improvement in the quality of referrals by the police.
- There is clear evidence of the shift in the culture of the police and of consideration being given to the wider context of domestic abuse when responding to incidents. The force now prioritises the reduction of risk and harm to children experiencing domestic abuse. This is evident at all levels of the force and is leading to improved multi-agency working at the frontline. The police have invested heavily in training frontline staff in the various strands of vulnerability, including domestic abuse. In all cases seen by inspectors, there was good recording and good recognition of risk. Children had been seen and spoken to when possible and referrals had been correctly completed and forwarded to the

MASH. Arrests of perpetrators, when necessary, have been timely and good investigations have followed.

- There was evidence of emergency departments completing detailed Domestic Abuse, Stalking and Harassment (DASH) risk assessments and 'thinking child' when seeing adults. Like the police, investment in the training of health staff in recognising domestic abuse has resulted in good quality risk assessments and referrals from emergency departments. The role of the Independent Domestic Violence Advocate (IDVA) at the Royal United Hospital is valued by staff in the emergency department, the maternity unit and the named professionals. Records examined showed the IDVA taking a proactive approach to undertaking risk assessments and seeing patients who had disclosed domestic abuse in a number of cases. Processes showed good onward-sharing of information, including a number of letters sent to inform GPs, in which the concerns around domestic abuse were clearly articulated.
- In adult substance misuse services, the assessment process following referral into the service is strong. The initial assessment provides an opportunity for practitioners to identify children and young people for whom clients have parental or carer responsibility or to whom they have access. If accepted into the service, a more thorough assessment is undertaken, with a further opportunity to explore domestic abuse in families. All assessments and risk assessments are reviewed every three months or when a client's circumstances change, such as when entering into a new relationship, so that current risk is well understood.
- In many cases, multi-agency plans were being used to drive forward progress and they were leading to improved outcomes for children and families. Good work was seen, which was reducing the risk posed by offenders, helping to build positive relationships and allowing children to live in a family where domestic abuse was no longer a feature of their lives. Several high-quality safety plans were seen, which were well considered and ensured the immediate safeguarding of children and victims.
- The Domestic Violence Disclosure Scheme, often referred to as Clare's Law, enables the police to disclose information to an applicant about previous violent offending by a new or existing partner when this may help to protect the applicant from abuse. Wiltshire Police was a pilot force for the scheme and consistently uses it to help to protect individuals and their children from abuse. There have been 204 applications made in this calendar year to date, and of these, 98 information disclosures have been made. Inspectors also saw evidence that both the number of applications and the proportion of disclosures made have increased each year since the scheme's introduction. In the majority of cases, the officer making the face-to-face disclosure is accompanied by an IDVA who can provide immediate support to the applicant.
- The Wiltshire Safeguarding Children Board and the domestic abuse sub-group promote, coordinate and prioritise the work of statutory partners effectively in

relation to domestic abuse. The chair, who was appointed in February 2016, has already had an impact in terms of ensuring a focus on practice, streamlining the executive group and ensuring that the voices of practitioners and families influence developments. The youth safeguarding board has recently been introduced, and members are already becoming involved with the development of online safety initiatives.

- A new joint domestic abuse needs assessment for Wiltshire is underway to inform ongoing strategy development and planning. Local areas are involved in developing their own needs assessments, with a range of voluntary and community organisations involved. Partnerships with voluntary and community agencies, such as Splitz, Spurgeon's and children's centres, are strong, and agencies demonstrate a passion for improving outcomes and broadening their reach. There is a good range of services available for families experiencing domestic abuse, with evidence of impact and improved outcomes. Links that midwives, health visitors and school nurses have with children's centres and Splitz promote joint working and ensure the engagement of families and children with accessible support.
- The domestic abuse strategy for 2017 to 2020 is currently being written, and a lot of work is being undertaken to understand the current prevalence and nature of domestic abuse across the county. Multi-agency and single-agency audits have been undertaken, including by Cafcass, to inform planning. There has also been work completed to understand the ethnic and diverse make-up of the county. Issues raised as part of this have led to further work to try to fully understand and meet the needs of particular populations, such as young people who are privately fostered within the Polish community. Inspectors were impressed with the level of consideration given to issues such as female genital mutilation, honour based violence and child sexual exploitation, despite them not being of high prevalence in Wiltshire. Training has been provided to assist practitioners to recognise when these factors may be a risk and to ensure that, even though the prevalence is low, when practitioners come across these issues they are dealt with to a high standard.
- There is a joint commissioning process, which listens to the voices of children and families to ensure that services provided meet the identified needs. An example of this was the inclusion of young people within the CAMHS transformation process, which led to the introduction of an online counselling and support service in direct response to their input. Inspectors have also seen some sensitive work undertaken by professionals to capture the voice of the child and involve them from a single-agency perspective.
- The multi-agency risk assessment conference (MARAC) is well attended by partner agencies and is well led. It is audio-recorded and actions are circulated to attendees in a timely manner. There was a good recognition of the need to provide appropriate support to children experiencing domestic abuse, and referrals were made to services such as post-natal health practitioners, schools

and school nursing. Training has been undertaken by a wide range of professionals in completing the DASH assessment, which has led to a rise in non-police referrals and to an improvement in the overall standard of referrals.

- The Multi-Agency Public Protection Arrangement (MAPPA) process is also well supported by 'duty to cooperate' agencies, with consistent representation at panel meetings. Actions are completed in a timely manner and updates are provided that describe the activity undertaken and its impact.
- The National Probation Service and Community Rehabilitation Company have maintained an evident commitment to safeguarding children during their transformation period. Agencies, such as children's social care, police, health, early help services, Splitz, CAMHS and housing, understand the split in probation services and are confident that they will continue to maintain good working relationships as the new organisations develop. They have been able to preserve effective arrangements in relation to their involvement in the MASH. This has been enabled, in part, by the CRC's decision to maintain their co-location of staff with relevant partners, which is good practice.
- The lead member of the council is a committed and passionate councillor who has worked with officers to drive forward improvements at a pace across the council. Vulnerable children are a priority for the whole council and members have demonstrated this commitment through, for example, committing funds to ensure the recruitment of high calibre social workers. This has led to a significant reduction in the vacancy rate, and an increase in numbers of permanent, good-quality social workers. The focus on developing a culture which facilitates good social work has had a palpable impact, and social workers, and their partners on the frontline, feel supported and valued in their roles.
- Feedback from those receiving services who were spoken to by the inspection team, was frequently positive. A parent who was the victim of domestic abuse told inspectors that: 'The support has been wonderful. The police have been extraordinary and the local authority has been great.'

Case study: highly effective practice

The Domestic Abuse Conference Call takes place daily within the MASH. It is chaired by the police. All domestic abuse cases that have occurred within the previous 24 hours are discussed, with partners being sent details of the cases to be discussed prior to the meeting. The DACC has representation from numerous agencies, such as the police, children's social care, adult social care, Storm (housing), Avon & Wiltshire Mental Health, Splitz, Army Welfare (when required) and Probation Services (via an email report).

The purpose of information sharing between the parties to the agreement is:

- to share timely, appropriate and proportionate information to safeguard victims of domestic abuse, including children, young people and family members
- to build on the initial DASH risk assessment completed at the point of incident, and agree on appropriate early interventions
- to ensure that perpetrators and serial perpetrators are identified, enabling more effective risk management for victims.

The key outcomes for the Domestic Abuse Conference Call are:

- people discussed at the DACC receive a rapid response and early intervention
- people discussed at the DACC are less at risk of escalation of domestic abuse
- reduced repeat incidents or re-referrals back into the DACC.

During the DACC observed, 11 cases were discussed. These consisted of one medium-risk case and 10 standard-risk cases. Four of the cases had children living with domestic abuse. Information sharing between the partners was good, risk factors were identified and appropriate actions were set.

The DACC is a real strength for the partnership.

Areas for improvement

In all cases seen, risk has been identified and appropriate action taken to safeguard children. Overall, the multi-agency approach to protecting children and to reducing

the risk of domestic abuse is strong. There are, however, a number of areas where responses could be further strengthened and these are detailed below.

- Overall, the local authority undertakes comprehensive timely assessments that recognise needs and reflect the voices of children. However, in a small number of cases seen, better recording of the voices of children who are either very young or who have a number of brothers and sisters would improve practice further. In these cases, it would be possible to consider children's experiences by such methods as observations of them within the family, the quality of their interactions and what they should be able to expect from good enough parenting.
- It is positive that when children's circumstances change, or when they have been involved with services for 12 months, a refreshed single assessment is undertaken. This good practice could be further improved by more engagement with partner agencies, for example, by involving the GP in the updated assessment, thus developing a more shared comprehensive view of any changes in the child's circumstances.
- Planning is working effectively for children, but written plans could be further strengthened. Written plans in children's social care and health could be more specific about what the concerns are, what needs to happen, by whom and in what timescale. Plans also need to be updated following meetings and then distributed to all relevant parties. In some cases, plans had not been updated or distributed, and therefore professionals and families were not aware of what progress had been made and what work was still required to achieve outcomes.
- In the vast majority of cases, strategy meetings work effectively to ensure that children are protected. However in two, which were already open to children's social care, strategy discussions, although considered, did not take place. The recording of the reasons for this was not clear. Action was taken to safeguard children and to reduce risk, but this could have been strengthened if it had been based on a multi-agency discussion to inform ongoing planning. Managers within children's social care, the police and health should ensure that there is a clear record of evidence that strategy meetings have been considered and that there is a rationale for the resulting decision. The electronic recording system in adult mental health services does not support the service sufficiently to prioritise the safeguarding and protection of children and young people. Children's names and dates of birth do not form part of client demographics and details are, if known, simply recorded within the practitioner's progress notes and are therefore easily lost. There is no routine use of alerts to ensure that practitioners and managers accessing the case record are immediately made aware of a child at risk or subject to multi-agency working.
- In some CRC and NPS cases, there was room for risk-management planning to be more robust and explicit about how victims, including children, would be protected. Equally, sentence planning, which tended to focus on addressing

offending behaviour, would benefit from a wider focus, drawing on partner agencies' plans for the family

- There is some inconsistency across health providers in ensuring level 3 safeguarding children training has been undertaken by identified staff in line with intercollegiate guidance. In particular, Salisbury Foundation Trust currently has 61% compliance, which is considerably below the 90% target. Level 3 training for frontline staff includes assessing and understanding the dynamics of domestic abuse and therefore is integral in supporting early identification and the management of cases. This further underlines the importance of practitioners from all health disciplines who have direct contact with children undertaking the training.
- MARAC is very positively viewed and is clearly having an impact on risk management. However, there is a risk that the IDVAs may be involved in actions that might be more appropriate for police or probation services. Health services need to ensure that supervision plans and MARAC actions are routinely recorded in maternity and community health records, as currently there is not a comprehensive record to inform the care planning process for children and young people in relation to domestic abuse.
- In a small number of cases examined within health visiting and school nursing, we observed a lack of professional curiosity being recorded, which meant that risk was not always picked up at an early enough stage.
- Health services should work with social care, police, NPS and CRC to understand better the complexities of the health landscape in order to ensure that appropriate health professionals are included in assessments, plans and decision making. This is especially pertinent when work involves general practitioners.

Case study: area(s) for improvement

Strong multi-agency working and information-sharing around domestic abuse could be further enhanced with some small changes to the systems. Below are some examples extracted from different individual cases seen by inspectors, showing how a small change in practice would have delivered more effective working.

The police collect extensive information when they visit a family in which domestic abuse has taken place. This is carefully quality assured and shared with a range of agencies, including all those represented in the MASH. The health visitor receives this record but it is not routinely sent to GPs. Health visitors are not confident about how much of this information they can share with GPs, and likewise not all GPs understand its relevance. When information is received by GPs, it is not always recorded on the child's file as well as the adult's file. As a result, a GP may see a child without knowing their history or what the risk may be.

In other case studies examined, we saw that adult mental health services clearly ask about domestic abuse but the limitations of their assessment tools reduce their ability to identify all concerns and to take appropriate action. They do not always complete a DASH assessment to help underpin their professional judgement. Information about the children they care for, such as names and dates of birth, is not routinely collected or recorded. When there is information pertinent to children, this is contained within the adult's progress report and, therefore, can be difficult to find. This system relies on practitioners searching through records to find the relevant information.

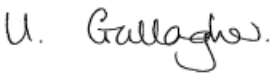
Next steps

The local authority should prepare a written statement of proposed actions responding to the findings outlined in this letter. This should be a multi-agency response, involving the police, health partners, NPS and CRC. The response should set out the actions for the partnership and, when appropriate, individual agencies.[2]

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's Chief Inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.

The local authority should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 27 March 2017. This statement will inform the lines of enquiry at any future joint- or single-agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Eleanor Schooling National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
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