

# Agenda Item 9



<u>Report Title</u>
TAC Overview Report

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<u>Purpose of Report</u>	
For Information.....	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
For Decisions.....	<input type="checkbox"/> Yes/ <input type="checkbox"/> No
For L.S.C.B. Action.....	<input type="checkbox"/> Yes/ <input type="checkbox"/> No

## **1. Introduction**

In January 2013, Lincolnshire Safeguarding Children Board (the Board) made a decision to conduct a multi-agency audit of cases within the Team Around the Child Process (TAC). This decision was made in order to assess the effectiveness of multi-agency early help as part of the Board's recently established Learning and Improvement Framework. The prioritisation of this audit was in part prompted by two significant cases; but also because of the wish to drive forward progress in multi-agency ownership of Lincolnshire's Early Help Offer.

## **2. Methodology**

Cases were selected at random from an anonymised list provided by the TAC Co-Ordinators. The review consisted of examination of 30 cases. These cases were audited using an adapted version of an Early Intervention Toolkit devised by London Safeguarding Children Board. The cases were considered by at least two professionals from different agencies, taken from a multi-agency audit team, who had not had any prior involvement with the cases. The case information audited consisted of (as a minimum): an assessment, a TAC Plan, and TAC meeting/review notes. In one case, where safeguarding concerns were raised during the audit process, these were followed up by the LSCB Business Manager.

Following this 'paper-based' exercise, more qualitative information was obtained from a cross section of 16 cases by conversations with Lead Professionals, and where possible families.

For this report, the findings of this audit are also supplemented by feedback from a range of frontline practitioners during the Board's delivery of locality-based TAC Training.

## **3. Analysis**

### **i. Audit Process**

The process has taken a significant amount of time and commitment from the audit team, and from administrative staff. It would have benefitted from a dedicated audit officer supporting the process. The toolkit used is generally good and fit for purpose, however, it was originally intended for use on audits where all agencies involved are around the table, and all case files are available. This has meant in some areas, the paper-based process did not give a full picture of the quality of work. For example, in some cases there was a substantial amount of paperwork, and it was difficult for the team to find the key evidence; in others where only the TAC paperwork was available, areas such as management oversight, were not able to be assessed. However, the conversations with Lead Professionals and families gave a more rounded picture.

For further audits more time needs to be allowed for agencies to access and collate records to be made available to the audit team. However, in an inspection environment this may not be possible, so agencies should examine their own systems here, as well as LSCB considering this issue.

Members of the audit team have expressed how much they have learnt through the process, and how it enabled them to have time to focus on this particular area of work in order to learn and see clear development opportunities for TAC in Lincolnshire.

### **ii. Early Identification**

From the documentation audit, early identification of need for children, young people and families was judged to be adequate or good in 20 of the 30 cases audited. Where this area was not scored (4 cases) it was due to lack of evidence on the paperwork available. In 2 cases where early identification was not judged as adequate, this was attributed to poor information sharing on step down from Child in Need, or poor use of historical information and concerns.

However, qualitative information from discussions with Lead Professionals indicates that recent training and supervision within agencies has increased confidence in assessment of need, leading to improved early identification and communication with Children's Social Care within many services.

iii. **Assessment**

The findings of the audit show that in 75% of cases children were appropriately involved in the assessment of need (Single Assessment or Initial Assessment), but that this is inconsistently recorded in TAC documentation. Where children were judged as not being appropriately involved, this was due to an emphasis on parental engagement and perception of need, rather than a focus on the child. Moreover, with regard to parental involvement in the assessment process, 87% were actively involved, but this was difficult to evidence from the TAC records alone. In two cases, Lead Professionals identified that there was insufficient involvement of fathers or absent parents in the TAC process. In the TAC documentation examined, there was little evidence of assessment as an ongoing process; however, in 63% of cases, the qualitative information indicated new needs being identified and addressed during the lifetime of the TAC.

iv. **Planning**

75% of TAC Plans considered during the audit were judged to be holistic and impact focussed. However, again, the documentation was often poor and inconsistent. Occasionally practitioners tended to focus on actions that fitted their roles, taking the focus away from the child's needs and wishes. However, in over 80% of cases Lead Professionals reported good and consistent agency involvement. Some written plans were adult focussed and not specific, timebound, nor measurable, and there is apparent confusion regarding whether there should be a separate plan for each child, or a collated family TAC plan. However, in 75% of cases Lead Professionals could demonstrate appropriate involvement of children and families and good recording of the voice of the child. Only one TAC case was evidenced to have closed because of parental disengagement in the plan.

v. **Review**

The audit team felt strongly that the current TAC documentation did not promote good practice in recording this area. It is not clear with whom the documentation is shared, and reviews do not consistently evidence progress nor impact. However, there is often a different picture within single agency case files. Therefore the documentation evidence did not reflect the actual effectiveness of TAC, rather the limitations of the paperwork.

Individual cases showed the following areas of concern:

- o Some 'drift' when there was a long time between reviews, particularly during school holidays
- o In one case, poor use of resources when some siblings are within CIN, and some within TAC. In this case there was two sets of multi-agency meetings with the same participants.

All Lead Professionals interviewed reported regular TAC reviews (between 8 and 17 weeks), and all but one said that agencies continued to attend. 75% of Lead Professionals of closed cases reported all needs being met on closure of TAC; with the remainder of cases being 'stepped up' to Social Care, apart from the one case where family had disengaged.

A more general theme is evidence of lack of confidence amongst Lead Professionals and practitioners to challenge other agencies and parents regarding lack of progress; although Lead Professionals cite training and supervision improving practice in recent months.

Also, within TAC documentation there is little evidence of a change in plan if the original is not working; but again case files and conversations often told a different story with significant evidence of reflective practice.

vi. **Management Oversight**

This was not assessed in 12 of the original cases due to this not being covered in current TAC documentation. However, there is evidence that most agencies have systems in place (for 87% of Lead Professionals interviewed); and demonstration that this is effective. From the original documentation review, the audit team felt that more structured recording of support and challenge was needed; but during the conversations with Lead Professionals most individual organisations recorded supervision and other quality assurance processes. Although the format and frequency of supervision varied across agencies, most Lead Professionals valued the opportunity it gave to reflect on individual cases. The primary concern for the Audit Team was that case supervision within Educational settings could not be

evidenced, and the same seemed to apply for Early Years settings, although only one Early Years Lead professional contributed to the audit.

**vii. Additional factors to be considered**

From discussions with practitioners, the following areas were consistently evident:

- Multi-agency training was cited to be the single most effective tool for giving confidence and skills to Lead Professionals.
- Current documentation was difficult to use, and not conducive to good practice.
- LSCB Escalation Policy was not consistently understood and implemented.
- TAC Co-Ordinator support was valuable, but more interface with Children's Social Care was desirable.
- Better leaflets for children, young people and parents/carers were requested.
- Capacity to undertake the role of Lead Professional was reportedly stretched in some organisations.
- Administrative support to the process was difficult or non-existent, leading to challenges for Lead Professionals.

**4. Conclusion**

There is no significant difference found in the quality of practice within agencies; the themes are consistent across all areas, apart from the issue of supervision and management oversight, which is particular to Early Years and Educational settings. Whilst the TAC process is embedded in Lincolnshire, there is clearly room for improvement in the documentation used, and the availability of records to audit teams. However, there is significant commitment to TAC as an effective means of early help to children and families, and this forms a good basis for development.

**5. Recommendations**

- LSCB to require the Children and Young People's Strategic Partnership (CYPSP) to establish a multi-agency TAC Steering Group to deliver the recommendations from this audit
- CYPSP to establish a mechanism for effective quality assurance of the TAC process
- CYPSP to review recording arrangements and amend all paperwork used for TAC processes
- CYPSP to make recommendations to agencies on expected standards of case supervision for TAC
- Locality based TAC training continues to be delivered regularly by LSCB; and all partners prioritise attendance of relevant staff.
- CYPSP to ensure sufficient resources are available so that practitioners have access to advice and challenge
- CYPSP to ensure the voice of the child is heard in all assessments, plans and reviews.
- LSCB actively raises awareness of Escalation and Professional Resolution Policy.
- Further audit work is undertaken with all agency case files available to the auditors.
- It is recommended that the Board consider allocation of a dedicated audit officer to LSCB.

**6. Decisions Required**

- ❖ Do the Board accept the recommendations above?
- ❖ How will resources be allocated to support the recommendations?
- ❖ What further work does the Board require?

## **7. Acknowledgements**

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