AN EVALUATION OF
THRESHOLD DECISION MAKING
BY LANCASHIRE COUNTY COUNCIL
EDUCATION AND CHILDREN'S SERVICE
ON THE PROVISION OF SUPPORT AT LEVEL 3 AND 4

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SUMMARY REPORT

Background

I qualified as a social worker in 1984 and worked in local authorities, managing systemic change across organizations and as a senior manager responsible for children's services. Latterly I was an Ofsted HMI for eighteen years and led over a hundred local authority inspections.

Focus

•To look at the thresholds document, Working Well with Children and Families, and identify how it is being applied at early help/children in need levels across the system.

•To follow the journey of children from the point of contact, at amber level, to a decision being taken to provide Early Help as a result of the MASH assessment.

•To look at children who have had a step conversation, following a decision being taken to refer for ongoing Early Help as a result of a Child and Family assessment.

•To identify from the evidence currently available the outcomes for these children.

Methodology

1. To conduct this work, I met forty-five workers and managers, and reviewed, with them, eighty current or recently completed cases.
2. All of the workers and managers I met were helpful, excellent representatives of the council and demonstrated well their professional skills and knowledge.
3. I also reviewed the documentation related to support to 320 cases including contacts, referrals, MASH assessments, early help support, child and family assessments and s47 enquires.
4. I visited the CSSH, MASH and duty and assessment teams in Accrington, Lancaster, and Chorley. I also had the pleasure of meeting staff and being shown around early help hubs in Skelmersdale, Church, Great Harwood, and Clitheroe.

Findings

5. Threshold decision making for most children referred to Lancashire County Council is clearly applied and results in good support being provided at the correct level. This high-quality response is not consistent, though, for all children.

6. The local guidance that underpins the multi-agency working at the front door Working Well with Children and Families in Lancashire has not yet been updated following the publication of the revision to the national framework (Working Together to Safeguard Children) in December 2023.
7. The focus in the local guidance is on single agency and multi-agency 'support.' It prioritises talking to children and working with families which is good. However, the threshold between level 3 and 4 lacks clarity in particular on the importance of the impact on the children of the issues and prognosis of future events which can, in the main, only be evaluated by formal assessments.
8. From the current guidance, early help staff (who support children and families at identified level 3) will – at times - be working with those that at least in the national guidance would be identified as children in need. This raises the question of the professional social work support they receive.
9. Due to a lack of clarity in the local guidance, other agencies struggle with understanding under what circumstances they should be referring both level 3 and level 4 concerns to children's social care.
10. There is much excellent work across the CSSH/MASH, early help, duty and assessment teams, including when there are child protection concerns, and this impacts positively on the lives of children and their families. Managerial oversight is evident at key decision-making points.
11. However, for some, decision making related to thresholds for support is not as consistent as its need to be. In part this relates to the guidance which lacks clarity, and the application of thresholds in the real world faced with complex family circumstances and histories, and limited information.
12. Lancashire County Council has invested well in a county-wide early help support service. This is well-resourced and targeted at those with additional vulnerabilities. This includes a well-coordinated set of early help hubs, additional support provided through schools and by other agencies and a focused and targeted service provided through children's social care.
13. The public, and other agencies, contact the CSSH or/and the MASH to make referrals when child and families may need additional targeted support. Too many contacts are being made, though, by other agencies which do not meet the agreed thresholds indicating that more work is still needing to be done with the wider children's services practitioners. The quality of many of these referrals are also poor, lacking in clarity on the situation and what needs to occur.
14. There are community family support workers (CFSW) who collaborate with schools and other agencies to give specialist advice and support when the early help (level 2) work is not making the changes quickly enough. Not always do the referring agencies consult with the CFSWs prior to making a

referral and the CSSH/MASH does not always inform them when they decline a service. These are missed opportunities to use a valuable resource.

15. In the main the CSSH evaluates well whether the circumstances meet the targeted early help ('level 3') criteria, and the MASH similarly evaluates robustly whether these meet the higher threshold for a child in need assessment or a child protection response ('level 4').
16. Much of the CSSH work is good but not all has the same high quality of response and recording. The vast majority of the MASH work is of high quality, identifying promptly what follow-up needs to occur.
17. Child protection concerns are identified well, promptly actioned, and multi-agency meetings coordinate the response to a high standard. At times, outside the specialist teams, the police take actions prior to discussions with children's social care even when this is not immediately ensuring the safety of children.
18. Due to resource issues, many police safeguarding referrals (PSRs) are delayed in being sent across – by over a month – meaning that the subsequent responses to lower levels of identified risk are not sufficiently in time. In the main completed PSRs, though, are of a high standard. Operation Encompass also means that there is useful information sharing across the agencies.
19. Posiitvely partnerships with parents and the child's voice are at the centre of all of the work.
20. In addition to the response to electronic communications, the CSSH/MASH also has many phone calls received each day which are responded to as 'call backs' (there were over seventy on the day I reviewed these in the MASH). These are not recorded on EHM/LCS or reflected in the performance data for the front door. There has been a recent review of how these are responded to, which is positive, however it is not clear why these cannot be dealt with as other contacts are to children's social care.
21. Child and family assessments conducted by the specialist teams across the county are in the main thorough and timely, with good consideration of the presenting issues and history. However, for a significant percentage (19%) there are repeat referrals due to the issues not yet having been resolved. This is often when there are ongoing domestic abuse and parental substance misuse. Some of these are stepped down to early help support. At times, consideration of the cumulative impact of events on the children is not robustly considered.
22. Across the CSSH/MASH, duty, and assessment, on some of the more complex cases not following a child protection pathway, work is not progressed due to repeated lack of consent. Whilst it important to work in partnership with parents, there is not sufficient consideration of the day-to-day life of the children. The process for dispensing with consent needs to be tightened.

23. Referrals for children with disability are not responded to consistently and recommendations for further support not always as comprehensive as for those children with dissimilar needs.
24. Ongoing support to targeted early help (level 3) cases is provided by the Family Intervention Service. Much of the work is excellent, benefitting children and their families lives.
25. There are families 'stepped across' from the CSSH/ MASH and following Child and Family assessments which turn out to be above their threshold for support and are clearly children in need. FIS workers continue to work tenaciously to try and address the needs. When this occurs, there is not always the needed additional social work support and difficulties stepping cases back to a more appropriate service.
26. The vast majority of the children and families transferred to FIS following a children and family assessment were appropriately stepped over following the threshold guidance. On these, excellent work was evident from the family intervention workers which has been successfully improving the welfare of the children concerned. There were also a small number, though, where level of complexity indicated that the threshold decision was not sufficiently robust.
27. There is much evidence of improved outcomes for children and their families who receive early help support in Lancashire. These services deliver helpful support building up the strengths of the family, enhancing parenting and building the confidence and resources of the children concerned. This helps prevent further crisis and potential family breakdown. The family intervention service works with some of the more vulnerable children and families and the majority of their work evidences improvements in family circumstances.
28. The CSSH and MASH do not specifically provide support directly to families but conduct brief evaluations and refer on to other services. However, there are contacts which come in requesting advice and help and ample evidence of workers providing guidance and assistance. Across the front door services, workers were listening sensitively to people in need and providing support which benefits the families.
29. There is much evidence of children and families benefiting from the work of duty and assessment social workers - either at s17 or s47 level - through the direct work carried out with the children and parents or through their coordination of multi-agency colleagues to work in ways that better meet the needs of the family.

<u>Suggested Actions:</u>

As a result of this report, the main actions suggested are:

- Continue with the review and publication of an updated Lancashire County Council Threshold guidance. Awareness raising and training sessions to be held within which the appropriateness of referrals to CSSH/MASH to be discussed

- For CFSWs to be notified if a contact is judged to be inappropriate by the CSSH/MASH, to facilitate timely discussions with the referrer on what further actions to take or to look at what services are available in that community that best meet the families' current needs.

- To support the police with being up to date with their completion and sending over of PSRs to the CSSH/MASH

- Develop a formal process for dispensing with consent, supported by legal advice, to ensure that children's day-to-day experiences are at the heart of any such decision making

- Further work to be undertaken to look at the current application of thresholds which have led to the higher level of cases going to FIS

- Review the use of call-back and consider whether this work can be actioned, recorded, managed in the same way as other contacts coming into the department

- Ensure that all the work undertaken in response to a contact is recorded in sufficient detail by the workers concerned, including who has been spoken to and their views. The worker responsible to be identified in the write up

- Ensure a consistent approach to undertaking child and family assessments for children with disability

- Ensure there is a formal system for professional social work support to FIS workers when faced with issues out of their level of knowledge and experience

- When cases referred to the FIS are identified as needing another level of support, there to be a timely process for stepping-across

REPORT

Background

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Focus

- To look at the thresholds document, Working Well with Children and Families, and identify how it is being applied at early help/children in need levels across the system.
- To follow the journey of children from the point of contact, at amber level, to a decision being taken to provide Early Help as a result of the MASH assessment.
- To look at children who have had a step conversation, following a decision being taken to refer for ongoing Early Help as a result of a Child and Family assessment.
- To identify from the evidence currently available the outcomes for these children.

Methodology

To carry out this work, I met 45 workers and managers, discussed their work and reviewed, with them, 80 current or recently completed cases.

All the workers and managers I met were helpful, excellent representatives of the council and demonstrated well their professional skills and knowledge. Everyone was child-centred and focused well on how they – and their colleagues- were helping improve children's lives.

I also reviewed 320 cases remotely, including evaluating contacts from other agencies, police safeguarding referrals, contacts, referrals, MASH assessments, early help assessments, CAF assessments and plans, TAF meeting minutes, C&F assessments and plans, supervisions, case (and general) notes, strategy discussion minutes, initial child protection conference minutes, and closure and transfer summaries.

I visited the CSSH, MASH and duty and assessment teams in Accrington, Lancaster and Chorley. I also had the pleasure of meeting staff and being shown around early help hubs in Skelmersdale, Church, Great Harwood and Clitheroe.

I was provided with performance information on the CSSH/MASH, Annex A information (lists 1-5), and local guidance/policy documents which inform practice across the county.

Inspection /External Review

Throughout this report, I focus on evaluating the quality of the work, commenting positively on the good work I saw, whilst identifying areas that could be further developed.

I also comment on issues which Ofsted inspectors, or other external reviewers, would likely note, which could impact on their thinking, or result in a line of enquiry or the making of recommendations at the conclusion of their work.

I have followed the Ofsted methodology of sampling case files, looking at specific issues and identifying themes from the work.

I use the word 'cases' to refer to the different processes and activities recorded on the electronic records of the family members.

Note:

At the time of this review, there were two issues which would be identified in an external inspection as potentially of concern:

a) Police referrals to children's social care – when they have identified, through their work, children who are 'at risk' – are significantly delayed. The number quoted in the CSSH/MASH December data is approximately 1700 children. I saw cases that the police had responded to in mid-December and were being screened by the front door in mid-January (34 days later). Ofsted and His Majesty's Inspectorate of Constabulary would be seeking evidence of the multi-agency view of this situation (through conversation with senior managers and the Safeguarding Board) and evidence that these delays do not put children at further risk.
b) The local guidance that underpins the multi-agency working at the front door Working Well with Children and Families in Lancashire has not yet been updated although the national framework (Working Together to Safeguard Children) was revised in December 2023. Ofsted would see it as essential that the framework for decision making locally reflects national good practice to address concerns and improve the outcomes for vulnerable children.

DATA ANALYSIS

The December 2024 statistics indicate that there were 4260 contacts that month, of which 3990 were evaluated by the MASH/CSSH. These numbers are reported to be less than in other months due to Christmas closures, including for the schools who at those times would not be contacting the front door.

420 of those 3990 contacts were screened and referred to children's social care for further work. This is 12% of the total. This low 'conversion' rate could suggest a lack of understanding of the agreed multi-agency thresholds.

568 were screened by the MASH, of which 433 were transferred to children's social care (this number does not appear to be consistent with the previous data), 91 received advice and support, and 19 were referred to early help.

Over that month there were 1820 police safeguarding referrals – 724 'high' risk which go to the MASH (again this number is not consistent with the reported overall number of MASH screenings) and 884 'medium' which go to the CSSH.

179 children have contacts for physical abuse, with 64 referred to children's social care (including for s47 enquiries and s17 assessments) (38%), 179 contacts are for neglect, resulting in 64 being referred into social care (38%), 167 contacts are for sexual abuse resulting in 43 being referred into social care (26%) and 43 contacts are for emotional abuse resulting in 3 being referred to children's social care (7%). There are also 17 contacts relating to exploitation, with 2 being referred to children's social care (12%). Ofsted data analysis would likely identify this as a potential line of enquiry as this appears to show a low referral rate into children's social care of those key significant harm issues.

Lancashire records when consent has been obtained. This is a complex area for a statistical return. The data indicates that consent has been obtained in 56% of contacts – either from a referring agency or from children's social care - to carry out a screening. This appears to be a low rate from an agency whose philosophy is to work openly in partnership with families. Further data would be helpful on how many of these the consent has been dispensed with as seeking this would have put the child at further risk of harm.

There has been 95% response to the agencies who make contact, describing the decision making and actions taken by the MASH/CSSH. However, feedback from DSLs contained in the MASH/CSSH newsletters identifies an unhappiness about the lack of specificity of that feedback.

The overall rate of re-contacts with the MASH was 26%. The data also details where individual agencies (for instance health, police and schools) have repeated contacts with concerns/requests for support. This data is normally considered by Ofsted and

other external reviewers to evaluate whether the front door is making the correct decisions.

The ethnicity data identifies that of the monthly contacts 3201 are 'white', 281 'Asian', 196 'mixed', 37 'black' and 509 where the information has not been obtained. With the diverse population of Lancashire, this appears to be a low rate of those from a non-white background.

The timeliness data identifies that 19% of CSSH contacts are not completed within three working days and 9% of MASH screenings.

On the data originally shared with me, there was no information on the activities undertaken in the CSSH. Further data was supplied at my request. This identified that the outcome destinations from both the MASH/CSSH in December 2024 were universal services 3111, early help 504, children's social care 420, existing early help 172, episode not matched 39 and no further action 14.

Suggested Actions: To consider how the performance data may be interpreted by Ofsted, or other external reviewers, and provide further explanatory text.

CSSH

There is a well-structured and resourced early intervention service in Lancashire. Agencies are signed up and supported to provide 'level 2' (single agency) assistance – with the network of family hubs helping. 'Level 3' (multi-agency) work is also equally supported. Key parts of this service are the more specialist Family Intensive Support team and Targeted Youth Support.

The CSSH is made up of social work qualified managers and senior social workers. There are also grade 6 unqualified social workers who carry out the level 2 screenings and grade 8 early help officers who carry out the level 3 screenings.

I met early help managers screening cases that had recently come in and observed level 2 and 3 workers carrying out the work identified by their managers. The work was non-stop due to the amount of work coming into the service.

It was described to me that currently the amount of the more complex level 3 work has increased, which provides challenges to completion within the timescales. At the time of my visit, contacts were 'stacked' – going back a couple of days – due to the large number of contacts and staff availability. It was described that 'stacking' always occurs – to ensure workers with only have six contacts at any one time - however not often causing these delays.

Many of the contacts I looked at with workers and managers – as they were carrying out the screenings/management oversight – were described to me as not meeting the local guidance for referral to CSSH/MASH. The managers described that they spend approximately 'two to three hours a day' screening cases that do not meet the criteria for the CSSH/MASH, are being sent in as 'information sharing' or /and do not have the necessary consent. Some basic work is still undertaken, for instance checking the history on EHM/LCS. These are then referred back to the referrer with an explanation and details of relevant services available in that area. This is a high use of CSSH resources with a manager describing that these 'take energy' from the more complex contacts where families need additional support.

Most of the work undertaken in the CSSH has an 'outcome' of referral to universal services (3111 in December 2024). From the available data, it is not possible to break this down further to those where it has been appropriate to be referred in, discussed with CSSH/MASH, with helpful advice given and where it had simply been inappropriate. The EHM system has an outcome of 'threshold not met/no consent' but local guidance is that this should not be used. This also means that there is a percentage of new contacts being recorded on the EHM system where the parents may not be aware.

This identifies an issue with other agencies understanding of the agreed Lancashire-wide thresholds.

Suggested Actions: It would be helpful for there to be records kept – at least for a brief period – to identify the extent of this issue. This can be discussed on a multi-agency strategic basis. With the new Working Together having been published, the Safeguarding Board will be updating and reissuing the guidance on thresholds and consent. There will be awareness raising and training sessions where this can be discussed, including when it is appropriate to make referrals to the CSSH/MASH.

CSSH CASES REVIEWED

THRESHOLDS

I reviewed a high number of contacts received from other agencies.

On all the cases managerial oversight is evident on receipt of the contact, in identifying what further work is needed, and in concluding what further needs to occur.

In many cases, the information from the referring agency was unclear on the concerns and on the impact on the children. Appropriate actions did not appear to have been taken beforehand such as discussions with parents and additional 'level 2' support. In the main threshold decisions by the managers on taking no further action were correct. There were a small number though where the presenting information was of concern and regardless of the process issues further exploratory action should have been taken.

Some cases are requests by parents for support. These, though, and other cases which are primarily about other agency concerns (including those from the police) are likely to contain issues about the safeguarding and welfare of the children. Many of these cases are potentially children in need, which would need further information to identify the most appropriate further level of support.

On those which are taken further as contacts, there is considerable screening activity including reviewing the new information and history. At times, parents, family members and other agencies are also spoken to. The recording of contact work, though, is too often limited and does not always evidence the work undertaken and the consideration of the relevant information.

Threshold decisions after the completion of this work are most often correct. However, the decisions taken - either to refer to universal services or for level 3 support - are sometimes not commensurate with the level of concern.

There is a recurring issue regarding the lack of consent and how this then stops further work being undertaken.

ANALYSIS

I reviewed Annex A, List One (Contacts) which lists 852 contacts for January 2025. From this spreadsheet, I was unable to identify any contacts that had been responded to by CSSH (rather than the MASH). I sought the assistance of the Lancashire County Council Performance, Development and Research officer who – carrying out a search on the names of the early help officers who work in the CSSH - could only identify 93 cases (30 different families) which had been dealt with by CSSH. This is likely to be leaving out large numbers of contacts which were dealt

with by CSSH. The Team manager in the MASH/CSSH reported that 'the data in obviously incorrect as I know the workers are non-stop and they are on the busiest team.'

Suggested Actions: On any Ofsted, or external inspection activity, focusing on the front door, data analysts are likely to pick up quickly that the numbers in the performance information are out of kilter with the Annex A spreadsheet. This needs to be resolved – or coherently explained - to prevent criticism of performance management systems.

On external inspections, Ofsted inspectors are likely to want to sample CSSH work to review the application of thresholds. If so, they will want to see a full list of the work undertaken by the CSSH and MASH to choose cases themselves.

From these 93 contacts, many were repeat recordings related to contacts with siblings. I reviewed those where the decision was taken to no further action/signpost to level 2 services. Although this only totaled thirty families, there were numerous other contacts for these cases within the last twelve months that I also reviewed.

There are challenges from any external reviewer in looking at the work being undertaken in response to a family's needs. Contacts/referrals/and case notes are not always recorded on every child in a family's casefile even if they are in the same household. It is therefore necessary to check other children's files for any relevant information. This increases the amount of work potentially needing to be done at the front door. It also potentially results in missed information. One example of this was information, I found on sibling's files, which had not been recorded and considered in a contact made for the older sibling (DPA).

Suggested Actions: Ensure that where there is a recording of involvement with one child in the family this is copied into all relevant children's files.

The nature of the contacts, I reviewed, included police safeguarding referrals (medium risk), children with mental health concerns, general parenting support, housing issues, neglect, lack of co-operation with other agencies, request for information, parents struggling with children's behaviors, behavior towards children, harassment and domestic abuse, parental mental health issues, substance misuse/physical fighting, child self-harm/going missing, community isolation and threats, concern about high risk offenders having contact with children, bereavement support/access to CANWs, and support to siblings of disabled child.

There was evident management oversight on all cases at allocation and on closure/transfer, a great deal of early help officer activity, and in the main this was completed in a timely manner. There were examples of excellent engagement with

families in crisis DPA) and clear and helpful advice (DPA DPA).

Other cases reviewed which demonstrated good work included the response to a racist incident, families living in other authority areas, a girl reported missing where mother declined support, a suicide attempt, a hospital admission (which turned out to be a medical issue), and a further CAMHS episode. The work undertaken was thorough and threshold decision making appropriate.

However, in the cases reviewed, the quality of the contact response was not consistently thorough, and the recordings were limited. This is often about the more complex family circumstances where the thresholds for involvement are less clear.

This reflects the challenges presented by the quality of many of the contacts from other agencies. These lacked specificity regarding what the issue was and on the impact on the children concerned. Workers and managers, though, reported that there had been improvements in the quality of contacts from the work of the Community Family Support Workers and the Education/Training rolled out across the external agencies. However, it is still not where it needs to be.

Suggested Actions: Ongoing work to continue with other agencies on thresholds and on how to make a referral that will be accepted by children's social care.

When a contact is received, and appropriate consent is not received, consideration still to take place on whether this needs further review from the information presented and previous history of the family.

It isn't always clear from reading the contacts who had undertaken the work – whether this was one, or several early help officers, or a MASH social worker. It would be helpful for this to be explicitly recorded on the contact. It is good that cases which are identified as needing a different level of screening can by transferred from the CSSH to the MASH. However, for an external reviewer, on reading the contact, it is difficult to see that this has occurred.

MASH workers, I observed on-site, also noted that when they received cases from the CSSH it was difficult to see what work had already occurred.

On too many contacts, work undertaken is recorded in only the most limited sense. For instance, it is not clear who has been spoken to and what their views are (on both contact forms and in general notes).

Some contacts are one-off requests for support. For many, these are part of a pattern of contacts (for instance, I noted on some that there had been 3, 4, 5, 2, 3, 7, 3, 3, 3, 2, 3, 4 other contacts, including some further contacts since in February 2025). In the main, recordings do refer to these previous contacts. However, they don't always highlight the key issues from those past contacts. Sometimes the

conclusions summarizing the issues don't pick up on all the key issues as described in the referral, identified in the work undertaken or/and from the previous history.

Suggested Actions: Ensure that all the work undertaken in response to a contact is recorded by workers concerned, including who has been spoken to and their views. The worker responsible is identified in the write-up. The managers continue to summarize their decision making with a brief evaluation of all the issues.

There is a recurring issue of a lack of consent from the parents. As noted elsewhere in this report, at these times, there is too often a lack of consideration of what the life experiences are for the children when making the decision to no further action/refer to universal services.

Suggested Actions: Ensure that when decisions are being made to no further action a contact, consideration is given to the child's lived experience.

As a result of these issues, there are several cases where Ofsted, or other external reviewers are likely to raise questions about the thoroughness of the response, either to this single contact or similar contacts over a short period of time.

In DPA , there are a range of concerns including school absence, lack of co-operation and neglectful conditions at home. There is a significant previous history. There is no consent but with the presenting issues and previous history the dispensation of this should have been considered.

In DPA , there is a contact from the school where it is reported that they had previously referred the child being 'slapped' by her mother, captured on CCTV, but they note that this wasn't taken any further by children's social care. Reviewing the previous contacts, this does not appear to have been referred by the school in the past. In this situation, there would be an expectation from Ofsted, and an external reviewer, that this would have been explored further with the school.

In DPA there were concerns from probation about mother's partner. He is noted to be a 'high risk' offender and a 'risk assessment' is needed. A response is sent indicating that the probation officer needs to brush up on thresholds and no action will be taken. This does not appear to be appropriate on the information shared.

There were three contacts in three months on DPA These are related to a young person's behavior, in particular assaulting other family members. Each time it was decided for this to remain on level 2. The school are saying that they are struggling to deal with the main issue – the child's behavior at home. It is also unclear whether mother has been spoken to in all the contacts.

DPA has a previous referral about a high-risk offender possibly being discharged to the address. There is a management oversight comment that the probation officer should be contacted about the late referral. There is no record of this occurring.

In DPA, there are 7 contacts before a MASH assessment. Other agencies continue to express concerns. Before the MASH, it is noted by the manager that 'we haven't got enough (concerns) to over-ride mum's consent'. This is probably not accurate. Following the MASH assessment, there was a strategy discussion, and an ICPC which resulted in the children being subject to child protection plans. According to the information provided, this could have been responded to more robustly earlier.

DPA, there are three contacts in six months. Some of the issues relate to a known high-risk offender in contact with mother. Recently advice has been given to mother on how to manage this and within the confines of the limited front door contact she replies appropriately. With the information received, though, this should have also been passed onto the police/probation/MOSOVA manager.

DPA has two contacts relating to an aunt asking for support for herself for a bereaving child who lives with her. The contact has come in via the children's school in Wigan. Advice is given on bereavement support for the child and that the school needs to put in an early help assessment before Lancashire support is considered. The second contact is from the Wigan School expressing frustration at the response they received although they then basically receive the same advice again.

In DPA, in a previous incident (which this contact relates to) when father slapped the 2-year-old in the face. This was not dealt with as a child protection incident. It is noted from mother that, 'father often feels stressed and she recognizes the signs which means she removes (the child) from father's care.' The mother has undertaken support for domestic abuse, but it appears that not only has father not, but according to a CAF assessment he doesn't know that mother has been receiving this additional support due to concerns about his reaction. This has been picked up as mother is now pregnant with the man's child and consideration is being given as to whether there are any heightened concerns.

DPA has three contacts relating to different alleged injuries to a small child. Police have visited although it isn't clear that they saw the child each time. Mother maintains that these are malicious referrals. On one of the contacts, from the nursery, it is reported that the mother has withdrawn her child due to injuries being received there. This appears that it should have had consideration of LADO involvement.

Many contacts report that, although there will be no further action in relation to this contact, signposting advice has been given and emails/letters sent. On most cases, there is no recorded evidence (for instance in general notes and documents) of these formal communications. These may go out from a general mailbox, however Ofsted, and other external reviewers, will be likely to want to see the evidence of the advice given recorded on the specific case file.

On one case (DPA) where mother is most likely to be seen as a victim of assault, there is a letter on file warning her to 'please make sure your children don't witness frightening behaviors'. This is not helpful communication. A similar message could have been made in a more sensitive manner.

Suggested Actions: When letters/emails are sent to referring agencies/parents/children a copy of these is stored on the child's file.

Proforma letters to be reviewed to see if there are more sensitive ways to communicate with families.

At times requests for information are received from other agencies, on whether children's social care is currently/ still involved with a family. In the contacts I reviewed, this includes information being sought from health, probation and an adult safeguarding social worker. The manager – or worker – documents that this information could not be shared without explicit consent. If PSRs are being shared with schools and health, then it is likely that these requests for information will already be covered by information sharing arrangements.

In DPA , an adult safeguarding social worker contacted to ask if there is current involvement and is informed that the information will only be given with consent. This is part of several contacts having been dealt with by CSSH in relation to concerns about this family.

Suggested Actions: Ensure that information can be shared by children's social care with other partner agencies when there are concerns about children's welfare.

On DPA there was little information, but the PSR reports that there was a series of grooming incidents at school involving several children and a potentially unknown perpetrator. The PSR is filed in general notes, however this records a different sir name and date of birth for the child. The PSR doesn't detail what the police action is going to be. Nothing is recorded as having been done by children's social care apart from noting that 'school are aware.' Ofsted, or other external reviewers, would be likely to note that this is an insufficient response.

DPA has been responded to recently. There have been previous domestic abuse related incidents. I found a PSR from 7/24 on general notes which does not appear to have had oversight from children's social care and whose information does not feature in the later considerations of events.

MASH

The MASH service is well-resourced with qualified social workers who are allocated to permanent teams covering the geographical Lancashire areas.

When contacts come in electronically there is oversight by the manager, who reviews the current presenting issue and the past history. They identify if this is potentially a s47 and needing an urgent response and record what the worker needs to do to progress the case.

All cases entering the MASH are thoroughly appraised by the workers although not all technically have a 'MASH assessment'. The work identified often includes talking to the referrer, discussions with parents and, with consent, finding out more information from other agencies.

If this is a child protection referral, this goes through promptly to the duty and assessment teams. If this is not a s47, there is a 24-hour timescale to evaluate whether the circumstances meet the threshold for social work (or early help support). In the main, the decisions made are no further action, signposting, level 3 early help support and level 4 children's social care (duty and assessment) support. Sometimes there is a delay whilst waiting for essential information from other agencies, but decisions are most often made in the 24-hour time scale.

Managers keep an overview of the progress of cases. At the end of the work, they review the worker's findings and conclusions and decide on the next steps.

Although transferred, internally, to the Child and Family Well-being service and Duty and Assessment teams, the cases are not always allocated. Receiving managers can decide that they wish for further information, that they don't agree with the threshold decision (in which case they come back to the MASH) or that they won't follow the specific of the recommendation or will not open for an assessment.

The workers I met were positive about the working of the front door, reporting the 'fantastic' benefits of the Early Help workers based in the office, how external agencies were getting more familiar with the threshold guidance – with positive comments given about the MASH Education team – and how the separation into localities supported good relations with the external agencies.

Workers described having reasonable, if busy, days. They talked positively about the amount of work they were allocated to undertake. They were less positive about 'call backs' describing them as an 'invisible' additional workload without any certainty about what those cases could involve.

Workers described when assessment teams did not take cases as 'frustrating' and a 'barrier' to providing help to families they 'knew they needed help'.

Despite the positive progress, an area which still caused issues for them was the understanding/acceptance of the application of thresholds by other agencies. This was described at times as needing 'difficult conversations' and 'decisions'. Health communications were identified as – at times – problematic with challenges getting information in a timely manner in the North of the county. There was also a view that Health personnel didn't always seem to understand the thresholds for child protection with contacts regularly coming in identified as needing a 's47' although the issues were not at that level.

Suggested Actions: Further work to occur with health colleagues on level 4 thresholds.

Further discussions to occur on a strategic/ managerial level on the promptness of responses from health.

Workers described that thresholds are progressively getting 'higher' for social work allocation - for emotional abuse, neglect and when appointments are missed. An experienced worker described that it is 'hard to get through what needs to get through'.

There is a theme seen through all the children's social care and early help work. Throughout the various stages of involvement, decisions are taken which of the children in the household will be provided with a service. As a result, some family members can be 'open' to children's social care whilst others are not provided with a service, or this is provided at a different level. There are examples in the MASH of requests from professionals working with another child in the household for siblings to be assessed for further services. Examples included from social workers in the family support teams and from CAMHS. Some other authorities would take a different philosophical position that a family is a system, and that support is provided to all the children in a household unless there are very specific reasons for this not to occur (for instance if there is a child looked after, placed elsewhere, they would not necessarily be subject to a child protection plan with their siblings who remained at home). There are advantages and disadvantages to both approaches. However, this does mean that less children are recorded as being provided with a service in Lancashire compared to some other authorities.

MASH CASES REVIEWED

THRESHOLDS

I reviewed a high number of cases responded to by the different MASH teams.

On the cases reviewed, there was clear management oversight on receipt of the contact, on identifying the work needing to occur and in concluding what needs to occur next.

Contacts from other agencies are not always clear. Some agencies refer cases as 'level 4', citing child protection issues, although the provided information does not evidence that level of response as needed. When cases are referred in by other agencies as 'level 4', even if it is decided that this does not need that level of support, the MASH continues to evaluate that work.

There is comprehensive social work activity, and detailed evaluations based on the presenting issues and previous history.

Threshold decisions for the MASH to undertake the work are appropriately applied.

In all cases, child protection issues are appropriately identified and stepped across in a timely manner to the duty and assessment teams for strategy meetings to occur.

In the main, there is good consideration of what further actions need to be taken. I evaluated the response to higher level safeguarding cases referred due to physical abuse, sexual abuse, emotional abuse, neglect, child exploitation, criminal exploitation, MAPPA concerns, female genital mutilation and modern slavery.

The threshold decisions were appropriate in most cases, evidencing robust consideration of the children's needs. There were a small number though where there wasn't sufficient attention given to the available information.

Threshold decisions related to domestic abuse were less consistent. There is evident good work but also at times insufficient emphasis on the cumulative impact on the children.

There is a recurring issue of lack of consent and how this then stops further work being undertaken.

ANALYSIS

I reviewed a high number of cases that had been responded to over the last three months by the MASH. This was specifically to look at threshold decision making.

All the cases were responded to well. There was clear management oversight, comprehensive social work activities, and robust evaluations based on the presenting issues and previous history. Conversations were held with parents and information gathered from other agencies when appropriate. Most of the cases were transferred

to duty and assessment teams and therefore only the essential tasks were completed to make this possible. When needed, on being transferred to the duty and assessment team, strategy discussions and child protection processes were followed.

Threshold decisions were clear and appropriate.

Amongst the issues that I saw leading to referral were physical assaults, a child with profound disabilities, carers assessments, sharing indecent photographs, a concerning history of domestic abuse, unaccompanied asylum seeker, potential grooming, missing/sex with older boy, domestic abuse/stabbing, honor-based violence, assessments requested so fathers can have contact with their children, exploitation, and an extended family feud with weapons.

There were a small number of MASH assessments that led to no further action. These were appropriate –with no Lancashire children involved, a serious domestic violence event without children being present and mother seeking a restriction order.

There were two cases stepped down appropriately to the FIS - where a 12-year-old allegedly had her hair pulled and was kicked by her mother. Mother denied this but she was requesting help; and poor home conditions where the family had worked with FIS before.

Themes

I reviewed a high number of cases that had been responded to by the MASH. All cases that are responded to have a reason for referral identified for LCS/EHM. I chose to sample cases that had been referred due to higher levels of safeguarding concerns including sexual abuse, physical abuse, neglect, emotional abuse, child exploitation, criminal exploitation, MAPPA (involvement), female genital mutilation, modern slavery and domestic abuse.

Sexual Abuse – The vast majority of cases reviewed showed a good examination of the issues at the MASH, appropriate responses including strategy discussions and child and family assessments and allocation when needed.

Physical abuse – There is much good work evident, with MASH reviews, s47 strategy discussion, assessments and allocation where necessary.

Neglect – this is much more of a 'catch-all' category and includes general concerns about the parental care which don't fit into any of the other categories. Concerns seen included a history of neglect, failure to follow medical advice, severe neglect leading to police using their powers of protection, pre-births due to concerns about the home circumstances, parents being drunk and incapable, and parental mental health concerns. Again, there is much good work evident, from MASH reviews to

assessments when appropriate. There are fewer strategy discussions – although these do occur when there are concerns about immediate harm - but appropriately child and family assessments are undertaken to identify the needs.

Emotional abuse – There are fewer referrals on emotional abuse than for the other child protection categories. This may be explained as domestic abuse has its own category. The range of contacts includes a request for a s37 report, a grandmother struggling to cope with her granddaughter's behavior at home, a young person with mental health involvement due to parental conflicts at home, the death of one of the SGO carers, and parents separated and father refusing to leave family home. All of these led directly to child and family assessments, which was appropriate to gain a better understanding of the family's needs.

Child Exploitation – good work is evident on all the cases. The MASH assessments appropriately consider the information and identifies the need for more detailed assessments. This includes a mother on an ante-natal visit reporting she has been trafficked into the country, a 16-year-old reporting that she had been raped, a 17-year-old being exploited (which shows good work to address the issues during the assessment), and concerns about a teenager in a relationship with an older man.

Criminal exploitation – good work is evident in all the cases. The MASH has carried out a clear review and passed the cases on to the duty and assessment teams appropriately and in a timely manner. In the main the issues being responded to are young people being involved in the sale/distribution of drugs with associated risk behaviors. A range of different interventions have been provided from being subject to a child protection plan to early help with child exploitation support. In a third of the cases the family withdrew their consent for continued involvement.

Multi-agency public protection arrangements (MAPPA) – there were only a small number of cases where the main issue was identified as the consideration by MAPPA. MASH reviewed these situations promptly and appropriately passed them to duty and assessment teams. Assessments were undertaken and when appropriate child protection plans developed. Two of the referrals relate to high-risk offenders being released from custody.

Female genital mutilation – there is only a small number of these referrals. Good work was evident from the other agencies referring to following the LCC child protection guidelines. All were appropriately identified and actioned by the MASH and resulted in child and family assessments. One which had more immediate concerns about the child potentially being taken out of the country also appropriately had a strategy discussion.

Modern slavery – there are only a small number of contacts with this as the main concern. They were appropriately identified and actioned by the MASH. On one

case DPA resettled from Kent, the children went missing quickly. As a result, there have been ongoing well-attended strategy discussions and continued work done to identify where the children are.

Domestic abuse – there are a significant proportion of contacts where the main issue is identified as domestic abuse. This is an area which potentially covers a range of concerns and where the CSSH/MASH response could be on level 2, 3 and 4. It is, therefore, an area which Ofsted and other external reviewers are likely to focus on.

In reviewing the responses by the CSSH/MASH, Ofsted are likely to question whether the thresholds are always in the right place. In the main, this relates to several recurring issues - that many of the cases have had numerous previous contacts, that parents (most often the mother) have previously changed their stories and welcomed the alleged perpetrator back into the family home, and there have been in the past withdrawal of consent for an assessment or/and ongoing work. Ofsted would likely note that in the decision making there is a lack of sufficient focus on what life is like for the children in the household.

These situations are the ones most impacted on by the delays from the police in sharing police safeguarding referrals.

Some examples of these issues:

DPA had four recent contacts resulting in no further action. These included an incident which was referred to MARAC. Most recently, mother uploaded to Facebook a video of one of the incidents which would meet the threshold for a strategy discussion. Consent is still withheld. It is noted that school will need to continue to monitor the home situation but there is no recording of this conversation/email having occurred.

DPA had three recent contacts with the last one resulting in a child and family assessment being undertaken dispensing with consent. Two previous contacts had been closed with the first one closed as 'unable to make contact with mum within the timescales' and the second one closed due to unsuccessful attempts to contact her again. The MASH assessment noted that the PSR indicates that this was the fifth incident in the last six months. Children's social care had not been aware of the further incidents and if they had this may have resulted in earlier social work action being taken. The additional PSRs have still not been received and so it is unknown what level their risk is. However, even if the police had judged these to be of a 'standard' level, when other PSRs had been forwarded due to higher levels of concern then it would have been appropriate to share those.

DPA – had two contacts in 2025. In the first, mother was not spoken to. In the latter, attempts to talk to parents failed. It is recorded that the school should be

advised of the lack of consent however it is noted that attempts to talk to the school were 'unsuccessful – no answer'.

DPA – this is not a domestic abuse referral, but it is coded as such. There is only one contact recorded. The PSR notes that the child was removed to grandparents as father was drunk, 'the fifth time in the last three weeks'. No other PSRs had been shared. This appropriately had an immediate strategy discussion and a subsequent child and family assessment.

DPA – there were six contacts in the last year. There are a range of issues including what are described as 'verbal incidents' (although mother reported that her partner 'had tried to strangle her'), violent assaults leading in injuries, no further actioned as mother said she was separating from her partner, mother presenting with mental health, alcohol-related and self-harming behaviors (this contact describes that the family had been subject to child protection plans till 12/23 which has not come across before). There are then other contacts related to events in another local authority area including attendance at a strategy discussion there. A strategy discussion has been held, and this recently went to ICPC, however it was decided not to make the children subject to child protection plans.

DPA – six contacts in 2024. A child and family assessment occurred and stepped down to FIS. There were issues about consent. Father removed one of the children to Poland and then contacted expressing his concern about mother's care and behavior.

DPA – five contacts in 2024 including heavy bruising, child being strangled, deteriorating mental health (identified as 'no role for children's social care'). The last contact was from MARAC asking for a re-assessment.

DPA - two contacts in 2025. These indicated that mother was seeking support, and the alleged perpetrator was still in the household. The details are confusing. FSS have recently become involved, which will be helpful to understand what is happening to draw up a plan of support at the correct level.

DPA is a domestic violence event involving a stabbing and strangulation. There is a history. Mother does not give her consent for any support. The manager notes that 'consent cannot be overridden. The concerns do not constitute significant harm'. The manager notes that further similar incidents will be responded to more robustly. A further incident was reported recently – and MARAC communicated that they thought that a strategy discussion should be held. This was dealt with by CSSH and transferred to CFWB. This response does not appear to be commensurate with the issues.

DPA reports many referrals to the police. In the main there is thorough consideration of the incidents /history. However, there was an incident on 1/12 (PSR

came in 6/1) where mother reported injuries – and the child was involved – caused by father. A letter has been reportedly sent to father giving him advice although there is no evidence of this in the child's electronic file.

Suggested Actions: Ensure when there is consideration of further action in domestic abuse situations due consideration is given to the previous contacts, the seriousness of this incident and the previous willingness of both parents to work on addressing the issues.

Ensure that when considering what actions need to be taken from the front door that the impact on the children, and their daily lived experience is at the forefront of decision making.

Discuss with police, and relevant safeguarding partners, that when previous 'high' or 'medium' risk PSRs are shared that any further incidents which are judged to be of 'standard' risk are also shared.

Although there is no comparative data available, from my own anecdotal experience, some authorities dispense with consent more frequently than the practice in Lancashire. The national guidance also emphasizes that lack of consent should not be a barrier to ensuring the 'safeguarding and the welfare' of children. There needs to be a robust process of dispensing with consent to ensure that the safeguarding of the children is at the forefront of decision making, and that actions taken are proportionate for the specific issue.

Suggested Actions: Develop a formal process for dispensing with consent, supported by legal advice, to ensure that children's day-to-day experiences are at the heart of any such decision making.

In addition to those cases, where I reviewed the threshold for decisions based on the presenting issue, there were also a number I reviewed due to the MASH having decided not to take any further action.

On many the threshold decision was correct, based on the presenting information, the previous history and what the family were indicating their needs were at this time.

However, there were a small number where the referral information wasn't given sufficient consideration. DPA - there were two PSRs on violence in the home. The school re-referred but this declined as there was no early help assessment. DPA – a history of concerns. Further contact from housing with new concerns. The response to housing is that they are told that there is no current involvement. DPA - This had several contacts from other agencies, including two by the school due to concerns about criminal exploitation. These were declined as they

were told that if these concerns were accurate there would then have been PSRs from the police. These lacked thorough consideration of the relevant issues.

Suggested Actions: When contacts are declined at the front door, there needs to be thorough consideration of what the information means for the safety and well-being of children in the household.

When other agencies are referring cases where they are already providing level 2 support, there needs to be consideration of the relevance of the issues for the core business of the referrer (for instance if the issue relates to specific issues at the family home and they are not visiting).

DPA I flagged up with the managers whilst onsite. Over a weekend there was a reported incident which led to injuries to a child. The Police made EDT aware. Neither visited the family nor made them aware of the need for a medical overview. Both the Police and Children's Social Care responded quickly on Monday morning including a visit to the children. A strategy discussion was then held.

CALL BACKS

Across CSSH/ MASH, there is significant work undertaken which does not appear in the data activity of these services. This is 'call backs' where professionals or members of the public leave a message as they wish to speak to someone for a discussion. There is a spreadsheet kept of these activities, but no EHM/LCS contact created. The day prior to my first visit to the CSSH/MASH had 74 call-backs.

The performance data from the CSSH/ MASH does not record this high amount of work coming into the service and therefore is inaccurate.

Advice is given, including signposting. For some of those I looked at, the response by the worker was in the way of a text message.

I was told that where the issues discussed potentially meet the threshold criteria, it is advised that the referrer re-contacts the front door. At that point, a contact form will be created.

New guidance, shared with me, states that where the call-back potentially relates to abuse this should be passed immediately to a social worker and if the child is not already known a new contact form should be written and the child/family created on the system.

There is a qualified social work oversight of the basic details of the call-back (a pro-forma completed by call handlers) and a decision who to allocate to follow this up.

The call backs can be written up on case notes if the child is already known on the LSC/ EHM system. From my observations, though, not all the work undertaken is then written up. Regardless, the completed work is not being reviewed by a manager on completion of the work.

Suggested Actions: Overall, it is not immediately clear though why these calls cannot be dealt with – actioned, recorded, managed – in the same way as other contacts coming into the department.

DOCUMENT REVIEW

WORKING WELL WITH CHILDREN AND FAMILIES IN LANCASHIRE
(Undated)

The document is undated. For Ofsted, and other external reviewers, it is helpful for documents to be dated so it is clear that these are up to date.

The guide describes '*working with families to build on their strengths and coming together across agencies to put the child at the centre of work.'* This underpins a strength-based approach to supporting families across agencies.

It describes '*the work of people who are alongside families when they are experiencing challenge should be geared toward building strong foundations and developing assets and resilience so that children and young people thrive. Equally, there will be times when, despite everyone's best efforts to support families, children and young people need our protection to stop them from being harmed.*'

It is unclear what the word 'equally' means in this context.

Four levels of support are identified (should this be levels of need?)

The guide describes four broad levels of need:

Level 1 needs - Universal
• Most children, young people and families will experience challenges in their lives that impact on their wellbeing. Most families will be able to weather these challenges (are resilient to them) either without help from services, or with advice, guidance, and support from universal services, including empathy and understanding.

Level 2 needs - Universal Plus
• Some children, young people and families will need support from people who know them well and have established relationships with them to meet some challenges where advice and guidance has not been enough to help the family achieve change or where a child or young person needs additional support to help them to thrive.

It describes '*children, young people and families with universal plus needs are best helped to find the right solution by those who already work with them, such as their health visitor, nursery, or school. They are able to support the family by coordinating additional support with local partners as needed.' And 'when children, young people and their family are supported in this way, an Early Help Assessment/CAF co-ordinated by a named person who knows the child and family best, will help to gather and analyse relevant information and co-ordinate work alongside the child and family.'*

Level 3 needs - Intensive support
• A small number of children, young people and families will experience significant difficulties and will need coordinated support from experts working with them to find

sustainable solutions that reduce the impact of challenge on the wellbeing and development of children and young people.

The guidance describes *'for children and young people whose needs are Intensive, a coordinated multi- disciplinary approach where people from different organisations with different skills, knowledge and experience work together with a family, will be best.'*

Later on, the guidance goes into more detail on who it is for –
Vulnerable children and their families with multiple needs or whose needs are more complex, such as children and families who:

- *Have a disability resulting in complex needs*
- *Exhibit anti-social or challenging behaviour that increases risk for themselves and others*
- *Experience neglect*
- *Emotional/ behaviour difficulties experienced by the child/young person*
- *Parental conflict or poor family relationships*
- *Domestic abuse*
- *Poor parental Mental Health*
- *Have poor engagement with key services such as school and health*
- *Are not in education or work long-term*
- *Families involved in crime/misuse of drugs at a significant level*

The document, so far, has not raised the issue of the impact on the child which is at the heart of the issues and the need of further assistance.

Some of these issues will also need a social work assessment to identify impact & prognosis before identifying whether this is a child in need. Disability will also need a child in need assessment/service as described above).

Level 4 needs - Specialist support
• *In exceptional cases families need specialist, statutory support that is designed to maintain or repair relationships and keep families together wherever possible.*
In some very specific circumstances, the needs are so great that children need to be away from their family to ensure that they are protected from harm and in these circumstances the local authority becomes their "corporate parent."

Elsewhere the guidance goes into more detail as to who it is for:

- *S.17 Duties - Children who are unlikely to achieve a reasonable standard of health and development without the provision of services.*
- *Children and young people who have suffered or are likely to suffer significant harm as a result of abuse or neglect.*
- *Children with significant impairment of function/learning and/or life limiting illness.*
- *Children whose parents and wider family are unable to care for them.*
- *Families involved in crime/misuse of drugs at a significant level that is impacting on the child's welfare.*

- *Families with significant mental or physical health needs that impact in a way which may be significantly harmful to their children.*

An aspirational section notes '*we will only request services at a higher level after we have exhausted the resources and expertise at the earliest level of intervention (other than when there is immediate risk of significant harm).'*

The national guidance refers to those children who have suffered or are likely to suffer significant harm.' This is different than the above's emphasis on 'immediate risk' alone.

The guidance does not appear to cover longer-term issues which may/may not present an immediate risk but have longer term serious impact.

As detailed in the list above, there are a range of circumstances which need a social worker's professional assessment and their support. These do not all need a test for whether significant harm is present.

There is potentially confusion here. There are two levels – those who are children in need and those who are children in need of protection. Not all children in need need protection. For this latter group, there can be immediate entry into the system without any other apparent needs.

To deliver this agenda, there needs to be *'a confident workforce with a common core of knowledge and understanding about children and young people's needs and the skills to work with families.'*

Ofsted, or any external reviewer, will ask how does Lancashire assure themselves on this?

The issue about consent is described but in the various sections it is contradictory. It is noted that *'consent is needed from children, young people and families at key points in their journey – and can only be disposed of when there is an overriding concern for the welfare of children, young people or families and their safety' but then states 'if a family or individual refuses to give consent but you are sufficiently concerned about a child/young person or vulnerable person and feel you need to share information anyway, you should explain this to the family.'*

The description of consent is important and should provide an important underpinning to the approach detailed in this guide. However, it needs to be better explained than here.

The guide notes that a professional can have *'a conversation 'with the CADS, CSSH and MASH where you do not share identifiable details of the family.'*

Potentially this can be quite risky practice as children's social care cannot then give informed advice when they cannot check whether they already know the family. Ofsted are likely to pick this up and ask how the authority reassures itself that

children are being appropriately picked up when other agencies have conversations with them.

Later there is a description of when families need additional help over and above that provided at level 2. *'If, after a period of working with the family, practitioners identify that a child/young person and their family would benefit from a more intensive multi-disciplinary response than they can provide or coordinate; they should discuss this with the child/young person and family, update the Early Help Assessment/CAF and complete a referral/request for support form. '*

It is not clear what the phrase' 'after a period of working with the family' – means in practice.

It is further noted in the specialist support section – '*For a child in need, a referral/request for support to Children's Social Care is appropriate when more substantial interventions are needed: where a child or young person's development is being significantly impaired because of the impact of complex parental mental ill health, learning disability or substance misuse, or very challenging behaviour in the home.*' And '*a social care referral/request for support is also appropriate where parent/carers need practical support and respite at home because of a disabled child or young person's complex care needs.*'

This does not cover all of the issues which could lead to a child being assessed as a child in need. It is not clear what 'being significant impaired' might mean. It does appear to be different than the definition in the national guidance.

It is further noted that '*children's Social Care will work with families on a voluntary basis, often in partnership with other professionals, to improve the welfare of the children/ young people and to prevent problems escalating to a point that statutory child protection intervention is needed.'*

From my reading of this guidance, there is then a level 5 level of support/intervention which is 'child protection /enquires under s47' however it is not differentiated as such. The descriptions of children in need /child protection are a little unhelpful. For instance it is stated '*there is no absolute criteria on which to rely upon when judging what constitutes significant harm' but 'professionals in all agencies have a responsibility to make a request to Children's Social Care when it is believed or suspected that the child or young person: is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority Section 17 Child in Need; Health or development is likely to be significantly impaired, or further impaired, without the provision of services Section 17 Child in Need; has significant developmental or disability needs, which are likely only to be met through provision of Children's Social Care family support services (with agreement of the parent or carer) – Section 17 Child in Need;*
(or) s likely to suffer significant harm…or/and has suffered significant harm – Section 47 Child Protection.'

There is an additional clause added to the guidance here which is not in the national guidance that this contact can only be done 'with agreement with the parent or carer' presumably unless this is defined as a child protection issue.

There is a long section on indicators of possible need. The following are edited sections.

Level 3 includes development milestones are not being met due to parental care, 'unsafe' sexual activity /sexualised behaviour, self-harming, parents/ carers failing to provide adequate care, domestic abuse, parents mental health/substance misuse significantly affecting care of child, may be subject to neglect, parents have serious mental and physical health difficulties impacting on the child.'

Level 4 includes failure to thrive, dangerous sexual activity, Nai, sexual abuse, evidence of significant harm or neglect, acute mental health problems, disclosure, risk of CSE, concerning behaviours that place them or others at risk of self-harm, family breakdown, unresolved/unsolvable couple conflict, difficulty accessing, privately fostered, abused others, victim of human trafficking ,involvement with gangs, and chronic serious domestic abuse.

There are reasonable steps taken here to describe the difference between level 3 and level 4 support. For instance, the description of level 3 identifies 'domestic abuse' as a potential indicator of need and level 4 identifies 'chronic serious domestic abuse'. Level 3 describes 'may be subject to neglect' whilst the level 4 description describes 'significant harm or neglect' (it is not clear but the 'significant' appears to also relate to 'neglect'). Level 3 describes 'unsafe sexual behaviour/ sexualised behaviour', and level 4 describes 'dangerous sexual activity'.

Many of these differences can only be identified through an assessment.
There are unresolved differences between the descriptions of the concerns which should lead to a referral to children's social care (national s17 guidance) and the above lists.

The lists above identifying the issues at level 3 (not dealt with in Lancashire by social workers or supervised by social work qualified staff but by differently qualified staff) is very wide and the threshold for the work identified as level 4 (undertaken and overseen by qualified social workers) appears to be higher than that within the national guidance.

<u>Overall</u>

The focus in the guidance is on single agency and multi-agency 'support' It prioritises talking to children and working with families which is good. However, the threshold between level 3 and 4 – (and 4 and 5 as there are evident and described differences between children in need and child protection) lacks clarity in particular on the impact and prognosis of the concerns which can often only be evaluated by assessments.

Before evaluating the quality of practice, from this guidance, it looks like that early help staff (who support children and families at identified level 3) will – at times - be working with children in need. This raises the question of the professional social work support they receive.

From the guidance other agencies are likely to struggle with understanding under what circumstances they should be referring both level 3 and level 4 concerns to children's social care.

NATIONAL GUIDANCE

The national guidance Working Together to Safeguard Children (December 2023) reports that '*all families can face challenges that make parenting difficult. Often families are able to overcome challenges themselves or with the help of relatives, friends, and services, such as schools, youth services, health visiting and mental health services. However, sometimes families will have more significant needs that require more intensive help and support.'*

It describes how *'agencies, organisations and individuals work together to provide help, support, and protection in early help, through statutory services under section 17 of the Children Act 1989 and through section 47 of the Children Act 1989.'*

To facilitate this, it describes that *'safeguarding partners should publish a threshold document, which sets out the local criteria for action in a way that is transparent, evidence-based, accessible, and easily understood. This should include:*

• the process for early help assessments, and the type and level of early help and targeted early help services to be provided under sections 10 and 11 of the Children Act 2004

• the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under: section 17 of the Children Act 1989 (children in need, including how this applies for disabled children); section 47 of the Children Act 1989 (reasonable cause to suspect a child is suffering or likely to suffer significant harm); section 31 of the Children Act 1989 (care and supervision orders); section 20 of the Children Act 1989 (duty to accommodate a child)

• clear procedures and processes for cases relating to the abuse, neglect, and exploitation of children; children managed within the youth secure estate; disabled children.'

Early help is described as *'support for children of all ages that improves a family's resilience and outcomes or reduces the chance of a problem getting worse. It is not an individual service, but a system of support delivered by local authorities and their partners working together and taking collective responsibility to provide the right provision in their area. Some early help is provided through "universal services," such as education and health services…Other early help services are coordinated by a local authority and/or their partners to address specific concerns within a family and can be described as targeted early help. Examples of these include parenting support, mental health support, youth services, youth offending teams and housing and employment services. Early help may be appropriate for children and families who have several needs, or whose circumstances might make them more vulnerable. It is a voluntary approach, requiring the family's consent to receive support and services offered. These may be provided before and/or after statutory intervention.'*

Children in need are described as *'a child who is unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired without the provision of services, or a child who is disabled.'*

Child protection (s47 of the Children Act 1989) is described as '*the set of multi-agency activities and processes that follow a concern that a child is suffering or likely to suffer significant harm.'* Whilst there isn't a specific description of what significant harm is, the guidance describes that practitioners should *'consider the severity, duration and frequency of any abuse, degree of threat, coercion, or cruelty, the significance of others in the child's world, including all adults and children in contact with the child (this can include those within the immediate and wider family and those in contexts beyond the family, including online), and the cumulative impact of adverse events.'*

Abuse is described as *'a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Harm can include ill treatment that is not physical as well as the impact of witnessing ill treatment of others. This can be particularly relevant, for example, in relation to the impact on children of all forms of domestic abuse, including where they see, hear, or experience its effects.'*

It describes the responsibilities of practitioners across the children's system. This includes when they identify that *'anyone who has concerns about a child's welfare should consider whether a referral needs to be made to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.'*

The guidance notes that, *'if there are concerns that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care.'*

It further describes that *'practitioners should be proactive in sharing information as early as possible to help identify, assess, and respond to risks or concerns about the safety and welfare of children. This may be when problems are first emerging (for example, persistent school absences) or where a child is already known to local authority children's social care. Sharing information about any adults with whom that child has contact, which may impact the child's safety or welfare, is also critical.* It adds that *'an early help assessment is not a prerequisite for a referral but where one has been undertaken, it should be used to support the referral.'*

It describes that consent is not needed to share information *'for the purposes of safeguarding and promoting the welfare of children.'* However, *'it is good practice to be transparent and inform parents/carers that you are sharing information...and seek to work cooperatively, where it is safe to do so.'*

On receipt of the information, the guidance describes the practical actions to be taken within children's social care. *'Within one working day of a referral being*

received, local authority children's social care should acknowledge receipt to the referrer and a social work qualified practice supervisor or manager should decide next steps and the type of response required.' And 'feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold and offer suggestions for other sources of more suitable support.'

It describes that *'under the Children Act 1989, local authorities are under a general duty to provide services for children in need for the purposes of safeguarding and promoting their welfare....To fulfil this duty, practitioners undertake assessments of the needs of individual children, giving due regard to a child's age and understanding when determining what, if any, services to provide.'*

The purpose of assessments is to *'determine whether the child is in need, that nature of any service required and whether any specialist assessments should be undertaken to assist the local authority in its decision making.'*

Throughout the support systems for children and their families, it is noted that *'in the context of a child-centred approach, all practitioners should work in partnership with parents and carers as far as possible...Working collaboratively will mean parents and carers have the best chance of making changes, and practitioners can make fair and accurate decisions about how to support children and keep them safe.' It is noted, though, that 'whilst collaborative relationships between practitioners and, parents and carers are important, the wishes and feelings of the child and what is in their best interest remain central to decision making.'*

FRONT DOOR DOCUMENTATION

It was very helpful to share additional documents with me. I acknowledge that these wouldn't necessarily be shared with Ofsted during an inspection. Overall, these are good documents, serving their purpose well. I will make a small number of comments which could be useful to consider when updating them in the future.

MASH Operating Manual, June 2024

Useful guidance for internal staff on how the MASH operates.

Children's Social Care MASH Action Plan, December 2024

This is a long document extracting comments from recently published Ofsted inspections and JTAI reports. This reviewing of the reports is undertaken across the country by providers.

However, turning this into an action plan – with RAG rating- is not necessarily of the greatest value. Ofsted reporting and Suggested Actions: should relate to the national guidance and it is this which services should be judged by.

Children's Services Support Hub and MASH Guidance Information Sharing and Consent, April 2023

Another helpful document, although the 'commitments' are possibly not quite in the correct order.

The section on motivational interviewing techniques is very helpful.

A strength of this, and the other documents shared, is the emphasis on transparency and working with families. In that context the use of the word 'tricks' here to describe facilitate conversations with families is unfortunate.

Top Tips Consent partner agencies

Good guidance explaining that the family should know what is being requested, the reason behind it and what they hope to achieve through children social care's involvement.

Consent: A short guide for parents and carers when accessing support and advice from Lancashire County Council, 2023

In the main a clear and helpful document. However, there are occasionally unnecessary acronyms and specialist language.

Note that across the documents shared, the grounds for over-riding consent vary. Here it describes (where) 'the risk to the child may increase' and later 'when there is a risk to your or another person's well-being'.

Suggested Actions: It would be helpful through the documents to have a consistent description of how/why over-riding consent occurs.

Children's Social Care guide for parents involved in the assessment process

Another helpful document.

It is probably too ambitious though in covering assessments, child protection enquiries, data protection and access to records. This loses the strength of focusing on communicating to the family about the partnership with them and transparency of the professional's work.

It is noted that social work assessments can take up to 45 days. Whilst this is accurate, it can give the impression that this will be a long process for the family, which most times will not be the case.

SWAY Newsletters

Newsletters between the MASH and DSLs demonstrate good practice and are helpful to promote interagency working and understanding.

Some of the examples of early intervention are potential safeguarding issues and it could strengthen the helpfulness if the reason for this not being progressed in this way was explained.

In the SWAY newsletter, January 2025, there is a section on Operation Encompass. Amongst other helpful information, it notes:

'You should record the outcomes and impact of your actions. Some schools have their own templates. Even if the police have acknowledged your pupil or student's presence during the incident, do not assume that the child has spoken to the officer. If a child provides you with further relevant information, you should contact the police.'

This appears to suggest that the school needs to follow up this notification directly with the child. These incidents will often need a more nuanced approach than described. Lancashire policy and practice may be more detailed in the expected response from the DSL and school.

Report on CSSH/MASH & CFW Pilot, April 2024 – October 2024

The focus of this work was to explore options to better address when there were *'periods of high demand'* and *'the Children and Family Wellbeing Service is often approached by Senior Leaders of the CSSH/MASH service for support in triaging cases at an Early Help level.*'

The report also refers to exploring '*knowledge gaps'* and *'process gaps'* within the CSSH/MASH around Early Help and *'identifying families returning through the front*

door with multiple lower-level referrals by triangulating these referrals, we aim to identify greater needs and risks... that could be supported through the CFW Service.'

It identified positives but also a need to develop better relationship with the north, central and south localities; that signposting to Family Hubs and community groups could be improved; stronger links could be developed with Community Seniors to ensure all schools are referred back to them if on a checklist; and responses to contacts could be standardised including ensuring contingency plans and consent statements are consistently observed. It noted that due to 'evolving thresholds' there needed to be more guidance issued.

If shared with Ofsted, feedback is likely to be that this isn't the clearest document in identifying the issues, what is going to be done in response, and how the actions are going to be monitored.

Enhancing the Early Help Offer, April 2024 version 2

This lacks clarity as a standalone document.

EARLY HELP

I visited four family hubs and a family centre and talked to thirty staff and managers to hear about the Lancashire-wide early intervention work and the strong links with CSSH and MASH and children's social care.

Level 1

Lancashire County Council, to its credit, has invested in developing a county-wide framework to support children and families. This has included a network of ten family hubs which provide a range of direct information and support from experienced council officers in partnership with other agency colleagues for those with universal needs and wanting additional support. These services follow the Department of Education appendix F framework although – unlike some other authorities - the local authority has not received any additional grant from central government.

When I visited the Skelmersdale Family Hub, a regular meeting was underway with over fifty representatives from different agencies in the community looking at how services can be further developed. This is an impressive commitment from the council and other agencies.

Local families can drop in to the family hub to look for support or can be signposted by other agencies working with them. There are also groups including for 0-5- and 5–11-year-olds, parenting and family support, and targeted youth support. There are also regular one-stop shops with a range of agencies available to offer support in that community. Another example of best practice here is experienced council staff welcoming them, listening briefly to their issue and directing them to the most helpful attendant agency. Following those meetings, that staff member receives feedback on how that session went and enquires if they still need additional support. Potentially, they can then be referred to for level 2 support.

It is possible for the CSSH/ MASH to refer families for universal support – based on a contact – from the family hubs in their local communities.

Level 2

Where parents, children and families need additional support to meet their needs and improve their outcomes, then the agency most involved can, in partnership with the family, undertake an early help assessment, develop a plan and then help deliver the work to make those changes.

Some of this work has a degree of complexity and may be outside the experience of the partner agency or the individual worker concerned. The local authority employs community family support workers (CFSWs) – based in the family hubs – to work with all the local schools, GP hubs and partner agencies – to offer practical help and

support for colleagues in identifying what needs to happen to support the family at this time. It was described that the post was set up as a 'professional to professional' role however that has changed.

All the support is based on consent and supporting families.

The Community Seniors I met reported that they were seeing the positive benefits of their work. They reported that they needed 'to take time' and 'be persistent' in communicating with the agency representatives. They also carried out training and invited speakers to events to increase the knowledge and skills of other agency staff.

There were challenges with the number of other agencies in their areas, some of which make few referrals whilst others were in regular contact. There continues to be issues about the thresholds and frustrations on the interpretation of these at times by the CSSH/MASH.

Some of the CSFSWs reported that a particularly vulnerable group of children are those that not attending school. Some schools do home visits but not all and therefore heightened vulnerabilities are not always picked up and referred.

It is the principle that when agencies no longer feel that they are in the best place to be the lead professional in addressing the family's needs that they can discuss this with the community family support worker who can also offer advice on the most effective means of communicating the issues and concerns with the CSSH/ MASH.

In the main, to move from level 2 to level 3 support, a contact (it was described as a 'referral' to me, but the CSSH/MASH language is that this is a 'contact') must be made to the CSSH/ MASH. CSSH will then review these and refer to level 3 support when they identify this as appropriate. There must already been an early help assessment drawn up.

When reviewing contacts into the CSSH/ MASH, a significant percentage of these contacts are not accepted (for data, see page 11). In the main, the CSSH would argue that this is because the contact does not meet the threshold for level 3 services; that there is no consent for this contact (and it does not meet the safeguarding criteria for dispensing with consent); or/ and that there hasn't been sufficient time for the identified level 2 support to be deliver the changes.

CFSWs, I met, described that some agencies do discuss the need to refer to CSSH/ MASH with them, and they can offer support, whilst others do not. They also note that 'the threshold is so high'. And sometimes the contact forms completed by the referring agency do not effectively communicate the seriousness of the situation.

The CFSWs report that agency colleagues are often very busy with their core business. Some of those agency colleagues openly acknowledge that they struggle to find additional time to support children and families in this way. The CFSWs

describe that it is a key part of their work to support colleagues from other agencies when faced with these issues and the ownership of this work has been improving.

Undoubtedly this work is hugely beneficial in supporting the provision of additional support to families in need.

CFSWs reported that the processes need 'tightening up' as everyone should be aiming at 'getting it right first time', which isn't what is happening now.

They also report that one of the key issues faced by other agencies is that they must complete an online contact form which is highly repetitive. So, for instance, it was described that the address of the family may have to be manually typed in six times. They say that this form is a 'timed' form and if it isn't completed within a short period of time then it must be started again.

The CFSWs report that sometimes the CSSH will contact them to tell them about a contact which has not been accepted. But they report that this is not consistent, so they won't know that they need to contact the other agency colleagues and explore this further with them.

The CSSH can make direct referrals to the partner agencies, following a screening, if it has been identified that a lead professional (and level 2 support) would best meet the needs of the family at this time.

Suggested Actions: It would be helpful is for other agencies to contact the CFSWs prior to completing a contact to request a level 3 or a level 4 service; that the online form is revisited to reduce the amount of time repeating basic information; and the CFSWs are automatically notified if a contact is found to be inappropriate by the CSSH to facilitate timely discussions on what further actions to take or to look at what services are available in that community that best meet the families current needs.

Level 3

Lancashire County Council have teams of family intervention workers based in the family hubs. Referral to their services is through the CSSH who from their screening work identify what needs to be occur. On receiving the referral, the FIS workers contact the family within 48 hours and see the children within 5 working days. They will undertake a graded care assessment – which could take up to 48 working days – and following that construct a plan with identified activities to address the family's needs. They will not wait till the end of the assessment period before taking needed actions. Again, this is a consent-based service.

FIS workers have a caseload, of approximately 22 cases, and are supervised. They carry out direct work with the parents and children as identified to address the issues. The issues being addressed include alcohol/ substance misuse, domestic

abuse, parenting skills, and children's additional needs. Building relationships is recognized as important in delivering trauma-informed practice. Children are though at the centre of their work from listening to what they're saying to having a good understanding of their day-to- life experience. Unlike children's social care, they work with the whole family.

There is also targeted youth support providing direct intervention to address the needs of older children. There are also domestic abuse workers and local IDFAs able to offer support. These are not case holders, and this continues to be the FIS worker.

The FIS workers bring an excellent range of different work experience and skills to support vulnerable families in Lancashire. This includes youth work, early years, education, transitions support, homeless young people, residential care, the charitable sector, community empowerment groups and social work. They receive appropriate training which assists them in carrying out their work and benefits the families. Many spoke positively about the motivational interview training they attended.

All the early help workers I met described that the FIS are working with 'children in need cases' and that these would have been formally dealt with by children's social care. They described that a smaller number were stepped up from level 2 for additional support.

Workers described that they thought the application of the thresholds was not always in the right place. This was described by one FIS worker as 'a lot come over carrying a high risk'. It was described that there wasn't always the necessary information from the CSSH to have made that threshold decision with that the previous chronology not been properly reviewed.

It was also reported, by many of the workers I spoke to, that once a case had been allocated to early help, even if inappropriate, then it was almost impossible to get those cases to return to children's social care. They had to continue to work with cases and assemble evidence that the case met the threshold criteria for level 4. Even when they were successful at doing this, and it was acknowledged that this met the level 4 criteria, due to the levels of risk they were reporting, they were frequently told that their request had been turned down as the social workers would not be able to carry out any different work than the early help workers. One worker described that *'when cases come over, we are told if there any issues come back, but it is impossible to get back over'*. Other workers described that *'it was common'* that they were asked to carry out more work to evidence that the case met the level 4 threshold before it would be considered by children's social care. They said that they had to use the language of level 4'. One group of FS workers described that *'it is all about language'*, which echoes the views from other agencies making referrals

to CSSH/MASH. FIS workers also reported an inconsistency in social worker managers on whether they would be willing to take cases from them.

Early help workers reported that the thresholds had changed and the 'vast majority' of cases they were working with were more complex with higher levels of risk. A worker stated that they were working as a social worker but not being paid at that level.

Workers described that they 'did their best'. However, there were some cases which they weren't trained in and received little support (outside their own managers and colleagues). This included children at immediate risk of coming into care, homeless young people and children with special needs. Several workers reported that the thresholds for children with disability were so high that 'no-one meets the threshold'. They also reported that it was 'a challenge' to get adult social care involved even when a situation evidently met their threshold.

They described that it was evident looking at the histories that some families could have been referred earlier by other agencies – before the higher level of complexity became embedded. Sometimes, the workers reported a referral went to the CSSH/MASH, however this did not result in allocation.

A worker in one of the groups said that I was probably looking at 'where's the early help' as FIS were getting involved far later when the issues had become more intractable.

There are weekly formal family discussions between a Practice Manager from duty and assessment, in children's social care, and the manager and relevant staff from the family intervention service. Other services can be involved, for instance exploitation workers to enable better informed decision making. The discussions occur when it is felt that the risk element is too high for the FIS to be the key workers. When duty and assessment agree and identify there is a need for them to carry out a social work assessment, the FIS attends joint meetings and continues to be involved, which is good practice.

FIS workers reported that some children and their families are, therefore, not getting the support they need to address their needs.

FIS workers I met had a good understanding of the importance of professional challenge if the children's lives were not sufficiently improving including being alert to parents saying the right thing but not then carrying out the needed change.

All the FIS workers spoke positively about their work. However, they also spoke at length about the higher threshold level of cases that they were now expected to respond to. They reported a lack of much needed advice and support. They also spoke about the challenges they faced referring cases back into children's social

care. This is problematic – not just because of the content on what they were saying, to me but if they were to repeat this during an inspection it would inevitably lead to recommendations in the report.

Suggested Actions: Work needs to be done to look at the application of thresholds that lead to some of these cases going to FIS.

It is not uncommon elsewhere for cases initially identified as on one level of a threshold being identified as needing another level of support. What needs to occur at this time is a process for speedy stepping-across.

There needs to be a formal system for professional social work support to FIS workers when faced with issues out of their level of knowledge and experience.

EARLY HELP CASES REVIEWED

THRESHOLDS

Much of the work of the FIS work meets the threshold for level 3 support and is appropriately being managed within that service. Excellent work is evident involving parents and, in particular children and young people, in building on the strengths within the family. There is clear evidence of children's lives being improved utilizing the skills and experience of FIS workers.

However, there is also work with children and families which is likely to be 'children in need', at least following the national guidance. The local guidance has a slightly different emphasis. Whether they are 'children in need' will need a social work assessment for that to be confirmed. These are families with highly complex issues either with a variety of issues around parental functioning seriously impacting on the children, or (and sometimes as a result) children behaving in a way which leads to dangers to themselves and others. There are regular contacts from extended family, the community, and other agencies including the police. Some of these are clearly above the level 3 threshold when stepped-across whilst for others this becomes evident. There are others where circumstances change and the level of risk within the family worsens.

FIS workers tenaciously try and work with these families. Managers look at alternative means of addressing the needs. Following 'family discussions' some are stepped back across to children's social care.

The management oversight on these does not sufficiently highlight the problems in delivering the service and the continued negative impacts on the children.

Some of these cases have been stepped-over to FIS as the parents declined to give consent to social work support. Some of these were identified as meeting a 'level 4' threshold. Following this, there are some cases where FIS has been able to work constructively and enable parents and families to make changes improving their lives. However, there are more where the 'consent' is in name only resulting in FIS monitoring unsuitable situations rather than being able to contribute to positive change.

ANALYSIS

I remotely reviewed a high number of recent cases supported at 'level 3' by Early Help. I looked at cases supported by the Burnley, Hyndburn, Preston, West Lancs, Chorley, Lancaster, Rossendale, Fylde, Pendle, South Ribble and Central teams.

I focused on thresholds and whether the cases being referred for early help assessments are of 'level 3' or whether they should more appropriately be dealt with by children's social care.

In the main I have looked at cases that have been screened at the front door and decisions made that FIS (level 3) involvement is the best team to address the family's needs at this time. Due to the nature of the work, consent was gained prior to allocation.

When contacts come into FIS, there isn't always a recorded oversight by managers, identifying the work that needs to be done. Although the management oversight from the front door is most often clear, it would be helpful if there was a consistent approach across the early help managers in particular as they may have a different view on what actions need to be taken and in what order.

Suggested Actions: Ensure a consistent approach to recording by managers when new cases come into the FIS teams.

Overall, the vast majority of the cases evidence good work from the FIS. This includes positive and timely engagement with the parents and children, early help assessments and plans, team around the child meetings, direct work with children and adults, and ongoing visits to address the needs of the family.

Assessments focus on the strengths in the family and in the main evident concerns are not avoided. It is good that there is a specific section detailing the children's views. Some of the assessments, though, are written in a less 'child-friendly' language than others.

The management oversight recorded at the end of all the early help assessments is a standard *'I confirm the issues and needs ticked reflect the needs identified in the assessment'*. Ofsted and other external reviewers would undoubtedly find this insufficiently personalized on this family and their situation and on this completed assessment.

Suggested Actions: Ensure there is a unique management oversight for all early help assessments completed.

Supervisions do occur regularly, however there are variations in how detailed and action-orientated those are.

Despite all the evident good work, and detailed completion of the documentation, Ofsted and other external reviewers would find it less easy to see the progress being made to improve the children's lives. Ofsted and other external reviewers would be looking to see the impact of the work. Supervisions are recorded at different levels of detail but often don't highlight the progress being made.

Suggested Actions: Consider revising the supervision template to ensure there is a section identifying the progress being made to address the families' needs.

Amongst the issues being responded to well: a first-time mother requesting support; teenagers at risk of exploitation; children and young people whose behavior at home presents risks to their parents or/and siblings; children and young people with mental health problems; homeless young people; housing issues for families; low level and recurring domestic abuse.

The main issues presented are the behaviors of children and young people and mental heath support. Interestingly, several of the mental health referrals come from CAMHS seeking additional support for the wider family.

Out of these cases, there were a small number where the recordings do not evidence that presenting risks had been explored as robustly as could be expected. For instance, DPA where the CAF doesn't mention that the concerned child has sexually assaulted another child, DPA and DPA where the potential risks of exploitation are not fully explored, DPA is a pregnant 17 year old with her own needs, DPA has issues about grooming, DPA the CAF does not robustly focus on all of the apparent issues, and DPA where concerns about physical & sexual abuse are not responded to (in this case as there was no consent). Note that DPA is a 5-year living alternately with both parents. On 27/1 the nursery contacted the nurse to say that the child had been assaulted, and it was requested that they find out more information. Nothing further has been recorded. In DPA the mother has mental health issues leading her to refuse for her child to attend school. The child is recorded as last having been seen on 6/12.

Suggested Actions: Ensure that where risks to children are suspected or known, that the CAF assessment and plans consider those issues, and these are discussed in supervision. Recording identifies the actions to be taken.

Although most of the work undertaken is of a high quality, there is a significant proportion of those reviewed which Ofsted and other external reviewers would identify as meeting the threshold for a child in need. There isn't a clear line between those which are early help (level 3) and children's social care (level 4). These include cases with known higher levels of complexity prior to FIS being involved – including repeated incidents, children being caught up in parental behaviors or/and conflicts, histories of non-co-operation, and lack of sufficient change to the underlying issues. For instance, DPA and DPA The majority of these have higher levels of domestic violence. There are also situations where parents or the children's behavior is such that they are posing significant risks to themselves or others. There is evidence, on many of these, of tenacious efforts by FIS workers to try and form a relationship and then make a significant difference to the children's lives.

Suggested Actions: Review the application of thresholds at the front door to ensure that the evident risks are fully considered when allocating cases to early help.

When a case is open to FIS and new police safeguarding referral comes in these are filed in the general notes section of EHM. It is not always evidenced that they have been reviewed although they often detail significant events. Some local authorities will record these as 'contacts' (and are therefore in 'forms') as a way of monitoring key information and concerns from other agencies.

Suggested Actions: Consider recording all PSRs as new contacts on EHM/LCS with evident managerial oversight.

Review of FIS cases that reportedly don't meet the threshold for level 3 support

As noted earlier when I met with FIS workers, they reported that they were carrying more cases that were above the level 3 threshold, their levels of experience and the support they were provided with. They also reported that they struggled to transfer those cases back to children's social care.

They spoke in general about this situation and identified several cases where this issue was most evident.

I reviewed seven of these cases. On all the cases there were higher degrees of concern (and risk) and lack of co-operation from the family. Consent in name only was a factor in most of the cases. There was therefore a lack of progress in improving the welfare of the children. Some of the cases had those issues on transfer whilst others – more commonly – were identified very quickly.

There is clearly an issue about a service which is built around families wanting to change being faced with situations where they don't, despite the concerted efforts of the FIS workers. If faced with these situations, then a decision would need to be made whether to continue (on an understanding that some contact is better than none), to discontinue and close, or to step back up to children's social care. Although there is a potential argument as to whether the case will meet meets the criteria for dispensing with consent in most of these specific cases there is consent from at least one of the parents.

All the cases show perseverance by the FIS workers.

Difficulties in providing support are evident in general notes, when appointments are not being kept and responses not received from the parents or children. However, the regular supervisions rarely forefront these issues and instead discuss changing the work further to try and engage with the families. If there are issues – and there are – these need to be discussed and recorded in supervision.

DPA is a young person with a ketamine addiction who is involved in drug sales and exploitation. Most of the recordings indicate that the young person did not want to return to FIS support and mother stated several times that she did give consent to their involvement. She wanted child in need support. There is one reference that

she has given consent to CFW support, but this is not supported by the other information. After some significant time, this has now gone back to children's services and support is being received as a Child in Need with exploitation support. With the evident risks and family views, this looks like this should have gone to children's social care earlier.

DPA is a young person whose adoption has broken down. The parents 'dumped' him at the police station saying they could no longer cope. There are issues about him being regularly missing from home and exploitation. With a child on the edge of care, this looks like this should have gone to children's social care earlier.

DPA is a complex child welfare case involving assaults, harassment, voodoo/black magic curses, and potential LADO involvement. Mother sincerely believes that she will die by 10 March. The complexity of this suggests this should be managed by a children's social worker.

DPA involves lots of incidents, physical assaults and parents are now separated. Recently, mother has refused to engage in any work. The child is with a father who has cooperated and been involved in protective work. The case is now appropriately closed. Where the child is now, this could have been managed within FIS. Earlier on, when the child was staying with mother, this probably should have been managed by a children's social worker.

DPA has issues about poor home conditions and mother refusing to cooperate. This has made the ongoing work by the FIS extremely difficult.

DPA has a child staying with grandparents on a court order. The police are taking some time to investigate whether to charge the mother with assault. In the meanwhile, the FIS workers have been advised that they cannot talk to the child about her experiences and then provide support to help her. There isn't a degree of complexity but a challenge due to the police advice on what actions the FIS workers could undertake. It is my view that if this was being managed by a social worker, this situation would not have been accepted for as long as it has been.

DPA is a situation that concerns me. There are very poor home conditions, mother has mental health issues and refuses for the children to attend school. Although this has recently been reassessed as not needing level 4 support, this is not supported by the evidence of serious neglect. A recent conversation with the HV describes her as saying that she is 'outraged' with the lack of children's social care involvement. This is another case which doesn't seem to look at what life is like for the children and the new baby in the household.

Suggested Actions: Review the process for stepping cases back into children's social care to ensure that the life experience of the children is at the heart of decision

making, recognizing that faced with higher levels of risk and complexity, families need to be supported by qualified social workers.

EARLY HELP CASES RECENTLY CLOSED

I reviewed cases which had early assessments completed in August and September 2024 and which were then closed after support was provided. All the cases documented good work with the vast majority, evidently improving the outcomes for the children and their families.

Thirteen cases were stepped down, four were stepped across and three were closed due to the withdrawal of consent.

Of the 13 cases that were stepped down, all showed positive engagement by the family and evident changes addressing the presenting issues. The work included responding to domestic abuse, substance misuse, parental mental health issues, young people putting themselves at risk, neglect and home conditions, child mental health issues, family breakdown, children with disability, a young mother struggling with a new baby, and a family assessed under the Homes for Ukraine scheme. On all the cases CAF assessments occurred, FIS workers visited regularly, TAF meetings coordinated the support, and management oversight was evident monthly. Parents and children were at the centre of the practice and their views were well represented in actions being taken and were documented on the files.

On a small number, though, although there was good work, the recordings were not as robust, and progress wasn't as clear. This included a lack of recent general notes (DPA) or notes that lacked sufficient focus (DPA).

Of the 4 cases that were closed, having been referred to social care for a more in-depth social work assessment or urgent action, the majority were stepped across due a new event or set of circumstances. This included an arrest due to possession of large amounts of class A drugs, a dentist reporting serious neglect, and amongst a continuing decline in the care of the children's mother's new partner had a long history of violence. Prior to this, on all of these, there was much evidence of work by the Family Intervention Service to address the concerns. On one case, DPA there were ongoing concerns by other agencies – including several 's47 referrals' from the school which were not accepted or responded to robustly. On only one case was there a family discussion DPA – which was accepted for a transfer – but prior to this no recording on the file of any increasing concerns including in supervision. Note in this latter case the ICPC apparently occurred on the 31/12, however the minutes are still in draft form.

Three cases were closed due to the withdrawal of consent. The issues included missing from home episodes, domestic violence incidents, and young people's risky behavior with some exploitation risks. On two of these, positive work is documented

prior to closure whilst on the other this had not started to occur. On the domestic violence case, DPA , it is described by the police that because of the incident the 'child was terribly upset and crying' and the work done by the worker highlights the 'traumatic' experience for the child. Only on one of these – which was about a young person's behaviors and the risk of exploitation - has there been a further contact since closure which was due to the child disclosing new information that her father was sexually abusing her and involving her in the supply of drugs.

In the main, management oversight is evidently helpful to coordinate the progress of the ongoing work. However, in a small number of cases, the recording of the supervision focuses on the detail of actions still to be taken with less of a focus on the overall progress being made.

On many of the cases, there is a recurring issue about recording. Most of the cases are 'closed' but there is no equivalent to the closure summary as seen in the LCS system. Supervisions sometimes cover this – but not in the same level of depth – and how this is recorded (if at all) in the case summary is variable.

Suggested Actions: The completion of a standard template for EHM would be helpful to summarize the position at closure if there are further contacts with the CSSH/MASH asking for help or detailing concerns or if these casefiles were to be subject to review by Ofsted or other external reviewers.

DUTY AND ASSESSMENT

I visited two offices, Lancaster and Chorley, and met **nine** social workers and **four** managers in the duty and assessment teams.

The Lancaster managers described that they receive approximately 30 referrals from the MASH every week. The majority of these are allocated to social workers to carry out s47 enquiries or /and an assessment. Some of those are not allocated as they are siblings, and it is identified that it is unnecessary to include them in the work. There are some where there are 'discussions' and 'challenge' as the managers do not think that the threshold has been met, which can be due to the MASH not having got hold of a key person.

The Chorley managers described that sometimes they go out quickly and visit a family to check out the facts and whether therefore this meets the threshold for an assessment.

Managers reported that there are still delays in police referrals coming in. An example was yesterday when the Chorley office received a PSR on an incident on over a month ago when the police arrested a man for human trafficking. When the duty worker went out, the potential victims had moved out.

It was described that the calling of strategy discussions was inconsistent by the police. The Police investigation team was much more consistent however if a potential crime is being dealt with in the wider police these do not always occur.

There are also some contacts that come in directly to duty and assessment from the police as they know that the situation is such that that service will be picking up the case. Overall, relations with the local police, particularly the specialist child protection officers, were described as good. An example given was the police being willing to alter bail if the work by the assessment team showed that conditions were unnecessary.

Managers described that they 'assessed a child as long as necessary' so some assessments can be completed quickly whilst others take the full length of time. They also reported in some circumstances – for instance for neglect and emotional abuse - they will carry out the assessment first before deciding on whether this needs a strategy meeting. They stated that, regardless, they would make sure that there was a 'tight multi-agency plan'. They also stated that there would be checkpoints at 10, 20 and 30 days to ensure progress is being made.

For s47s, they need to decide by day 5 whether a case is going to a child protection conference. This is ensuring the booking arrangements for that conference. If it is decided that due to additional information that a conference is necessary, they will then arrange a further strategy meeting to keep within timescales.

Following the completion of assessments, it must be decided 'who is best to deliver the (identified) support'. Transferring cases to family safeguarding can result in a 'healthy challenge' and 'good discussion'.

The Lancaster workers were described as having caseloads of between 10 and 18. In the Chorley office, workers reported they had up to 30 cases.

The workers were enthusiastic, knowledgeable about their children and families and described developing good relationships with them to facilitate purposeful intervention. They often described their persistence in gaining an understanding and working with the family to initiate positive change.

Although the workers were confident – and could demonstrate their understanding and work – their descriptions often lacked a clarity. Frequently cases were described as 'complex' and then the workers spent too much time unnecessarily detailing this which didn't always help make the point they wished to make.

Suggested Actions: It would be useful for work to be done with workers in interview skills, for instance when meeting an Ofsted inspector, or any external reviewer, so that they can more effectively demonstrate the quality of the work undertaken.

The workers talked positively about the strengths-based approach underpinning social work in Lancashire. A social worker described that this was 'not just picking at problems but looking at the strengths' within the family. Motivational interviewing and an increase in direct work tools were also praised.

The workers in the Lancaster office, but not only, described that there were often challenges moving their work on – after the assessment was concluded – so that families moved on 'at the right time'. Part of this was due to having developed relationships with families when they were in crisis and needing to pass on the ongoing work in a sensitive way and part of this was waiting for workers in the Family Safeguarding teams to be available to take on a case.

ASYEs spoken to, reported good levels of support through the Social Work Academy and in their respective teams. They were less certain though whether they had smaller and protected caseloads than their colleagues. They described carrying out child protection investigations and undertaking court work for children to come into care. In interviewing them on those higher-level cases, they were less robust on describing the risks they were assessing.

ASYEs carrying out child protection enquiries would be undoubtedly picked up by Ofsted and they would look at how robust the response was to those high-risk situations and what support was being offered to the workers concerned. It is not uncommon for there to be a recommendation at the end of the inspection/visit for these arrangements to be strengthened.

Suggested Actions: Consider protecting ASYEs from highly complex cases such as leading child protection investigations and court work.

In my review of assessments, many focus on the presenting issue and on the parenting views of this. On some there is less focus on the previous history. Workers understandably take a positive view about changes possible – and possibly being demonstrated – however I would question at times whether sufficient weight was being given to significant events in the past.

DUTY AND ASSESSMENT CASES REVIEWED

THRESHOLDS

The thresholds for undertaking a child and family assessment are clear. All the assessments reviewed were appropriate. There was good consideration of the family's strengths, and of the potential obstacles to delivering changes. There was good communication with parents and children, other family members and other agencies.

In most cases the decision making, at the end of the assessments, was clear and addressed well the issues within the family. In the main, the decisions of which level of further support – if any – could be offered logically followed the work undertaken. These, mostly, followed the threshold guidance.

However, there are some weaknesses. Approximately 20% of referrals into children's social care are repeat referrals. These already had child and family assessments in the last year. There are some areas where the issue is not connected to the previous concerns. However, there are others where there are repeat referrals (and contacts) which are about similar issues.

In a small number of cases, the assessments didn't focus sufficiently on the seriousness of the presenting issues or on the history. On some there was at best an overly positive view of the parents' ability/willingness to change. On reviewing the cases, the issue of alcohol misuse came up several times with a lack of sufficiently robust response. Consent is also an issue here.

My concern here is the lack of sufficient consideration of what the daily life is like for children, faced with ongoing adverse circumstances. The current local threshold guidance doesn't sufficiently address where there are ongoing issues impacting on children's lives.

As noted, there are some families which absolutely meet the threshold for level 3 support and are appropriately stepped-over and the subsequent work makes a positive difference to their lives. However, there are also other complex cases where the family intervention services would struggle to make a difference, and this would delay work being undertaken, which would improve the children's lives.

ANALYSIS

I reviewed twenty recently completed assessments, undertaken by duty and assessment teams across the county. I focused on whether they met the threshold for a child and family's assessment and whether the decision making at the conclusion of the process was appropriate.

The internal 'referral' forms are not always clear on what are the key issues, however the more detailed 'contact' forms describe well the actions needing to be taken and the reason for these being identified.

Most of the assessments are of high quality – focusing well on the presenting issues with consideration of the previous history. They show good communication with the family, direct work with the children/ young people and liaison with other key agencies. Consent is well-considered in identifying what needs to occur next. Threshold decisions for assessments to be completed are appropriate. Identified further work by social work or early help teams is clearly explained and logically follows the work undertaken.

There are occasional appropriate delays due to changes in circumstances or new information coming to light. In a small number of cases, the allocated worker was unable to complete the work, and this was then transferred to another member of staff.

Management oversight is appropriate and evident, with supervision also recorded on case notes. There is some variation in the recording of supervisions, most are action-orientated, however some are not specific for this child/family and others focus more on the detail of the problems.

I looked at four assessments undertaken where the presenting issue was a parent requesting support for a child with disability. All four were identified as needing a 'carer assessment' – all four had child and family assessments, two had carer assessments completed, three had 'indicative budget needs assessment' completed. Altogether these assessments came across as less robust than the other assessments I reviewed. In DPA it is unclear whether the work has been appropriately completed with a comment that 'a further assessment is required as the worker has left the authority'. Case notes at the end of January 2025 also note that mother is having difficulties contacting a social worker. DPA was 'referred for a disability needs assessment' however the last recording is on 9 January, and it is unclear whether this has been progressed. In DPA, mother complained that she asked for support '4/5 months ago and not got a reply'. The conclusion of this assessment is that 'parents need to access the resources within the community' which may be accurate but is less specific than the identified follow up for other families – on the other assessments I reviewed - where the issue is not a disability. DPA evidences good work with a handover visit with the assessment worker and worker from the children with disability team.

The threshold for the children with disability team – as detailed on DPA – is children with a recorded diagnosis of 'severe and profound' disabilities. This is not uncommon however Ofsted and other external reviewers, in seeing the range of complex issues (mainly here ADD) where child and family assessments were being

undertaken, would be asking about the range of lower-level support services available, and how these are being coordinated and the market influenced by children's social care.

Suggested Actions: Ensure a consistent approach to undertaking child and family assessments for children with disability. For an inspection, prepare a briefing for Ofsted and other external reviewers to describe the support services available for those with identified disability needs (i.e. where the child meets the definition of a child in need as defined in the legislation however is not receiving a service from the specialist team).

Of all the twenty cases examined, the vast majority of their LCS records do not either have case summaries or these are significantly out of date. It appears to be the policy not to write summaries during or after an assessment if this does not lead to social work allocation. This is a missed opportunity. Ofsted, and other external reviewers, are likely, when reviewing work remotely, to start by reading the summary. Summaries are useful for recording the actions taken and the progress made through the social work involvement.

Suggested Actions: Ensure that case summaries are completed during and are updated at the end of the assessment. This is to describe the nature of the issues, work undertaken and the plans to meet this family's needs.

As described earlier, I met workers from the duty and assessment teams and reviewed recently completed examples of their work with them. I later also remotely reviewed a quarter of those cases (DPA DPA) looking at the application of thresholds, the key documentation, recordings, management oversight, and the resultant support being offered to the families involved. In all the assessments, there was good and thorough information gathering and analysis, involving parents and children, consultations with other agencies and reviews of the history. Strengths were recognized and issues about parenting and concerns appropriately considered. On these cases, there were appropriate transfers to Family support/Children in Need, level 3 early help support, referral to level 2 universal support or no further actioned.

CASES STEPPED DOWN TO EARLY HELP FOLLOWING A CHILD AND FAMILY ASSESSMENT

I reviewed twenty cases which had recently been assessed by the duty and assessment teams, support needs identified, and the decision made that this could be best provided by the FIS teams.

The vast majority of these were appropriately stepped over following the threshold guidance. On these good work is evident from the family intervention workers which has been successfully improving the welfare of the children concerned.

There were a small number of cases where consent had not been gained for the work outlined (or consent was immediately withdrawn following the step-over).

There were also a small number of cases where the tasks identified by the duty and assessment social workers did not fully cover the identified issues (which if they had, would probably not have resulted in the step-over to FIS as they then fell outside the remit of the service). Those issues though were still of considerable importance to the families.

On four of the twenty cases, the decision to step-across was probably incorrect due to the high level of concerns and the lack of co-operation from the parents.

To describe the good work:

DPA is about 'low level conflict', not attending health appointments and not sleeping in her own bed. The threshold is appropriate and good work evident.

DPA is about the impact of domestic abuse, mental health issues and the development of a personal safety plan. The perpetrator is in prison. The threshold is appropriate and good work evident.

DPA is about a 'dangerous' person being released from prison. It was passed to FIS for safety planning. It will be re-opened to children's social care and be reassessed when he is released. Thresholds are appropriate and good work evident.

DPA is about the support to a young person who has recently disclosed that she had been raped three years ago. The threshold is appropriate and good work evident.

DPA is about support to children with a terminally ill mother and a grandmother moving in from Poland. Thresholds are appropriate and good work evident.

DPA is about high-risk domestic violence. The perpetrator has bail conditions in place which the mother is keeping to. It is not clear that it does need additional early help support. Thresholds are appropriate and there is evidence that there is very good work working with the four children separately.

DPA has a number of issues including father being found unconscious in the street, several domestic violence incidents and an unborn child in the household. Support and direct work are evident, with the TAF meetings particularly helpful in coordinating the work. Thresholds are appropriate and good work evident.

DPA is about domestic violence and health related issues. This was assessed several times by children's social care. The threshold for transferring to early help – which occurred for a short period of time – was appropriate although it could equally have been supported as a child in need.

DPA is about a young person whose relationship with his mother has broken down and is staying with a family friend. This has been assessed by children's social care several times. Thresholds are appropriate. The consent was later withdrawn.

DPA is about a young person with substance misuse issues who was also provided with independence support. The threshold was appropriate. The consent was later withdrawn.

DPA has several contacts and referrals which have been considered by duty and assessment. This was stepped over to FIS and the threshold was appropriate, however a lack of cooperation and further incidents probably should have led to step-back more promptly.

DPA is about the ongoing parental, mental health and young carer support following the completion of a carers need assessment. The threshold is appropriate. There are no records on EHM yet.

DPA has number of issues around drug dealing and exploitation. There have been many contacts/referrals and no consent given to children's social care involvement. The focus of the early help work was on the exploitation. Although this is above the threshold for early help, in the circumstances it appears appropriate. Support has been offered but a lack of cooperation means that there is little progress.

DPA has lots of issues including relationship building, parenting support, mental health support, healthy relationships, school attendance and keeping safe. The thresholds appeared to be appropriate but there was then a re-referral to children's social care following a MASP meeting identifying concerns about child exploitation which had otherwise not been a feature.

DPA is about anti-social behavior, drug dealing and mother's suicide attempts. Direct work and support were provided. Increasing concerns for the other children are noted and a family discussion is being considered.

DPA was about physical and emotional abuse by stepmother. Her own children had been removed. The assessment identified that there were 'no safeguarding concerns' however contradictorily a focus of the early help was identified 'to complete some work...on the impact of physical and verbal abuse on children'. It has only recently transferred so too early to see the work undertaken.

On two cases consent had appeared to be given during the assessment however further support was declined when early help was offered. In DPA there had been issues about 'cruelty', neglect and common assault. It had been identified that the children were 'not at risk of harm'. Following the assessment, the parents declined further support. In DPA the assessment considered a 'dangerous' person

having contact with the children. Support was then declined. This issue of withdrawal of consent resulting in the identified support not occurring is not considered when concluding at the end of the assessment.

In a small number of cases, the threshold decision was probably not correct.

DPA has been assessed by children's social care several times in part due to alcohol abuse and the impact on the care of the children. It was stepped over to FIS despite mother not wanting to talk about her alcoholism. This was later transferred to children's social care following mother being arrested for neglect. The threshold was probably not correct with mother's refusal to talk about the key underlying issue.

DPA is about crime, neglect, drug misuse and mental health issue. The parents are reported to have had 'difficulties engaging with children's social care' due to their past histories. The focus of the early help is on a narrow range of issues and not all the concerns identified in the assessment. This provides some challenges to the work that needs to occur with the family. Regardless, good work is evident.

DPA is about a young person seriously assaulted by her mother, with then a further serious incident. This was assessed by children's social care several times. The tasks identified for FIS only covered some issues identified in the assessment. The young person is now looked after.

DPA has been assessed by children's social care several times. There is a long history of neglect, contacts and referrals. There were too many issues of high concern where FIS were going to be unable to enable sufficient changes.

Suggested Actions: When cases are being considered to be stepped-over to FIS, this needs to be given on the basis that there is consent for all of the issues identified needing to be addressed. Assessments should consider what needs to occur if consent is withdrawn.

The tasks identified should cover all the relevant tasks needing to be accomplished with the family and these should all meet the threshold guidance for FIS.

REPEAT REFERRALS

I have positioned consideration of this issue here as -although the issues could cover work done by FIS and CSSH/MASH -in the main this is about threshold decision making within the duty and assessment teams.

I reviewed twenty cases where it was identified that there had been 'a repeat referral' in the last twelve months. On a full inspection, Ofsted and other external reviewers, would remotely sample 'repeat referrals' – identified from Annex A – to look at the application of thresholds and the robustness of the decision making.

In Lancashire a repeat referral is where a case has been evaluated by the MASH and stepped across to the duty and assessment team for a child and family assessment to be undertaken. This could be under s17 or s47. In all of the cases I reviewed, the assessment did not recommend further social work support. Cases were being no further actioned or stepped down to either universal support or Early Help support from the Child and Family Wellbeing Service.

From Annex A, List 3, over the last six months there have been 3693 referrals. Of those 700 are repeat referrals (19%). For 633 cases, there has been one other referral; for 60 cases, there has been two other referrals; for six cases, there have been three other referrals; and for one case there have been four other referrals. Many of the cases with repeat referrals have also significant numbers of contacts detailing further concerns or requests for assistance which have not met the threshold for allocation to children's social care.

These repeat referrals do not represent most of the work undertaken in the duty and assessment team but are probably some of the more complex cases outside the child protection route.

On all the twenty cases, I reviewed every referral and contact that had been made over the last year.

Out of the twenty cases I reviewed - in seven of the cases, the decisions made were appropriate. In the main, on those, assessments are undertaken, are comprehensive and the decision making of stepping down/no further action is proportionate to the presenting issue. Further support is identified as assessed and needed. Other unrelated events occur, or situations significantly deteriorate, which then result in new referrals. This includes where the initial concern is not supported by the evidence gathered by the assessment, which is comprehensive, from the gathering of relevant information from the wider partner agencies and the work undertaken with the parents and the children.

On the other thirteen, though, there were missed opportunities to intervene. Across the cases, there are a number of recurring issues which impact on the

robustness of the decision making. In particular, parents refusing to give consent to further involvement where it is decided that there is not sufficient evidence to dispense with this; where the seriousness of the presenting issues and the past history are not given sufficient weighting; where there is a lack of focus on what this situation(and circumstances) means for the day to day experience of these children; and where there is a lack of understanding of the impact of alcohol dependency on children in the household. There is also a recurring issue of children not attending school, resulting in no-one providing any external scrutiny of the household.

It is important that consent is considered in all cases and in principle it is better to work in partnership with parents to identify issues and achieve change. Where consent is declined, I would have expected to see an evaluation and recording of the potential impact on the children of the lack of external scrutiny and a robust documented process considering the other actions that could be taken.

DPA had two MASH referrals resulting in allocation to duty and assessment, with four additional contacts. There are a range of issues here including the young person's mental health, self-harming and suicide ideation, harassment and sexually harmful behavior. There was a safety plan agreed with mother, and it was transferred to FIS as *'the threshold for significant harm was not met.*' The school continued to raise appropriate concerns and were advised to *'follow their own safeguarding procedures*' (which they were doing). Eventually, there was a strategy discussion which identified that there is a *'long history of neglect and family dysfunction...multiple referrals...which have not resulted in the desired change.*' This – with the disagreement with the school – should have been resolved much earlier.

DPA was allocated in FIS and had four family discussions but the transfer repeatedly was not accepted 'as no consent'. It is noted that *'child exploitation risks evident...not sufficient evidence to override consent'.* No strategy discussion was held.

DPA had four contacts and two referrals /transfers from MASH to duty and assessment. This involved ABH/ dealing/neglect. Mother declined consent. There were strategy discussions on the two older children, but it was decided that it was not '*proportionate to overrule mum's consent regarding the younger children'*. The assessment doesn't consider what is going to improve for the children without external scrutiny/support. Mother withdrew her consent. Another strategy discussion was later held which included consideration of her lack of co-operation. The children are now subject to child protection plans.

DPA is a child who is seriously assaulted leading to a hospital admission due to a 'bleed on the brain'. This is allocated to FIS as the child was not currently living with her parents. Other serious incidents occur, and the case remains with FIS. At one point it is noted in supervision that there should be *'consideration of case to be*

taken to family discussion' although no record of this happening. The child became homeless and is now looked after.

DPA is about a young person involved in drug dealing and exploitation. There have been several referrals and contacts of similar issues with a common element of a lack of consent. This is currently with FIS and father is quoted as saying that he thinks that the situation is 'getting worse'.

DPA has 7 PSRs about anti-social behavior and child exploitation. Mother does not give her consent. At times it is (probably) wrongly noted that 'there is no recent information that the child is being actively exploited' and at the conclusion of one strategy discussion that the 'concerns are substantiated but the young person is not judged to be at continuing risk of significant harm'. Following further arrests by the police, it has been allocated.

DPA has three MASH transfers to duty and assessment and three additional contacts. This included the father being drunk in charge of a dangerous dog and the child being with drinkers in the town centre. In both the father declined consent. Most recently it has been allocated following the possession and threats of using a knife from another child in the family.

DPA has two MASH referrals leading to allocation and two additional contacts. Issues included possession of a knife, exploitation and no school attendance. This issue of non-school attendance is noted regularly for these cases which is concerning as there is no one then with eyes on the welfare of the children. There was a strategy discussion which identified that the concerns *'were substantiated but not at risk of significant harm'*. Consent appears not to have been given. There were then more concerns about another sibling but no 'evidence to override consent' despite the younger children are reported as needing support. Eventually this resulted in child protection with a recent core group criticizing the lack of earlier involvement.

DPA had two assessments. The decision making was inconsistent with a step across to FIS due to *'mother wanting to work with other agencies'*. However, it is noted that if there was to be a further incident then a strategy meeting would need to be considered. Further incidents – including in communications from the school – with an ongoing lack of cooperation from the parents – did not result in this occurring.

On four of the cases reviewed, there is a common weakness of a lack of robust consideration of the impact of alcohol dependency. DPA had three assessments in the last year and 12 additional contacts. These included an assault on a child, domestic violence, home conditions, alcohol abuse and neglect. The children are now subject to child protection plans but it is hard to work out the logic of this not happening much earlier. DPA initially is about issues of violence at home. Two

assessments are conducted. It is transferred to FIS where mother refuses to give consent to talk about her alcohol related problems (which are a major trigger for the issues at hand.) The police are called out and mother arrested for neglect resulting this going into child protection. DPA had 3 MASH referrals to duty and assessment and 3 additional contacts. Mother was hospitalized due to her drinking and the children taken by the police to their uncle's. It was closed as the children were seen to be safe as they were staying with their uncle. They returned to mother's care soon after. Mother claimed she was 'abstinent'. A few days later she was found highly inebriated on the train with the child. The child is now subject to a child protection plan. DPA had several alcohol related referrals including ones which led to the *'baby (being) dropped'* and another a *'child injured'*. Acknowledging that the children were being impacted on it was decided that the parents would be *'offered the opportunity to demonstrate change'*. This was closed and a month later the parents were arrested again as heavily intoxicated. The children are now subject to child protection plans.

A recurring issue is that cases are being transferred to FIS to carry out identified task-centred work, but these tasks do not cover the full range of concerns about family life which leaves FIS struggling to address concerns outside their thresholds.

Suggested Actions: – to develop a robust process when considering the impact of the dispensing of consent. This to specifically include the consideration of the impact on the children in the household.

When carrying out assessments and making decisions on ongoing support due consideration to be given to the impact of children not attending school and parental alcohol misuse.

CHILD PROTECTION CASES REVIEWED

THRESHOLDS

All the cases evaluated met the threshold for child protection. These were appropriately identified and transferred over by the MASH to the Duty and Assessment teams promptly. Strategy discussions were held, appropriately and quickly. These were well-chaired and attended by key agencies. Discussions focused well on the current and previous concerns. Actions which were then decided responded to the seriousness of the issues and the need for further action.

The s47 enquiries were thorough, involved seeing the children and discussions with the parents, and liaison with other agencies. These were recorded well.

Some of these cases did not subsequently follow a child protection pathway, after the completion of the enquiries, but this was appropriate, and assessments were still undertaken.

Threshold decision making after the assessments was in the main clear and appropriate.

There were a small number of cases where it was decided to immediately step down to early help where the concerns identified are more level 4 issues.

Analysis

I reviewed twenty cases where child protection enquiries were initiated and responded to by duty and assessment teams across the county. This included five cases which had gone to ICPC, and the decision was taken not to make the children subject to a child protection plan.

My focus was whether the threshold was appropriate for a strategy meeting, and subsequent s47 enquiries, and for that to be discontinued, to conclude that further child protection planning was unnecessary and to go to a multi-agency conference.

When child protection enquiries have been identified as necessary, the quality of the work is high. Strategy discussions are well attended by relevant professionals across the agencies, current concerns explored, and history discussed, and a shared view of the way forward agreed. This appropriately considers potential risks and strengths within the family. Timely visit are undertaken and children seen as soon as possible. Further strategy discussions occur to discuss the assessed needs and future options.

Even when concerns are 'substantiated', there is a clear consideration of potential future risks and strengths. Decisions are taken as to whether the family need support at this time, and then whether early help or children's social care would best to provide that assistance.

Some of those are stepped over to FIS, although the risks remain high. Although they did not meet the threshold for child protection planning, some local authorities (and their safeguarding partnerships) would be more likely to identify these as children in need. For instance, DPA which describes 'multiple reports of physical abuse by mother' including most recently an injury due to the mother having 'grabbed her hair and punched her.' This has been passed to early help for additional support, and with a plan identified that will improve the home situation. DPA has been to ICPC three times and seems peculiarly uncoordinated, with social workers reporting to the conference that they don't agree with the children being subject to plan. The current early help work, though, is not being effective with mother not doing what she needs to do.

This issue of holding a child protection conference where the social worker disagrees with a plan being made is complex. Whilst a child protection conference is a multi-agency forum where particularly challenging concerns can be shared, it can feel uncoordinated if the social worker is not supporting a child protection plan. An example is DPA I&S – where the sibling died unrelated to the parental care however where other injuries were identified in the post mortems which could not have been caused accidentally. Regular strategy meetings have been called and this is good. There is much good work evident here, in what is a complex and sensitive situation. This went to ICPC, and the social worker reported that they did not feel this needed a CP plan. Another legal planning meeting is referred to as being needed and further consultations with a QC. Children in Need work continues.

It is arguable that DPA meets the criteria for a s47. The manager who authorized the strategy discussion minutes notes that they disagree with the decision and that this could have been managed at a lower level.

Suggested Actions: Ensure when cases go to child protection conference, the approach of the local authority is coordinated.

There were three cases DPA) where the presenting issues were of one of the children's behaviors (in two cases, drugs and weapons, in another, the child's disability) and the impact this was having on the other children in the household. None had concerns about parental care. For some authorities (and safeguarding partnerships) these would not necessarily have been a child protection enquiry. It isn't immediately obvious why these need a s47 response rather than, for instance, a child and family assessment and if that identified significant issues about parental care then a s47 could be commenced to facilitate a child protection conference being called.

Suggested Actions: Consideration to be given to a non-child protection route when there are no concerns about the parent's care.

Of the five cases that went to an ICPC, the decision to not make the children subject to a child protection plan was appropriate. In two cases, the issue was a child's behavior, in one case a child changed their disclosure that they had been physically chastised, and in two cases mothers had 'turned their lives around' (after significant histories of alcoholism and domestic abuse). In the latter two examples, one mother continued to be supported through children in need processes whilst the other (DPA) had declined further assistance including, after the conference, early help increasing the risk of further similar referrals. As noted previously, it is arguable whether those cases that had come to an ICPC due to the children's behavior are best supported through the child protection route.

The 'child protection conference outcomes' and the chair's summaries note that the children have not been subject to a child protection plan. However, they don't always explain in detail the decision making behind this if the concerns are substantiated but circumstances have changed or/and the risks reduced or/and alternative support packages would protect the children. This is relevant if those circumstances were to change, and future decision makers would need to review and decide on what course of action to take now.

Suggested Actions: For Child Protection Conference chairs to be clear – if it is decided not to make a child subject to a child protection plan – the decision making behind this on what needs to happen if those circumstances change.

On reviewing remotely other cases, I came across DPA This is a family with a disabled child whose behavior impacts on the other children in the household. The circumstances are not obvious ones which would result in child protection enquiries, child protection conferencing and a child protection plan. In the discussions held with the parents at the ICPC, they are told that 'so much extra support can be accessed when a child is on a child protection plan'. They are also told that the categorization of 'neglect' does not relate to their parenting but is a description of the disabled child's 'self-neglect'. If Ofsted, or another external reviewer, were to review this they would be likely to question whether this is an appropriate application of child protection and would note that children shouldn't be subject to a cp plan so that they can access additional resources alone.

Suggested Actions: Ensure that children are not made subject to a child protection plan so that they can access additional resources alone.

SUGGESTED ACTIONS:

STRATEGIC ISSUES

1. (INSPECTION-RELATED) To resolve the discrepancy between the performance data and Annex A spreadsheet on the number of contacts coming into children's social care
2. (INSPECTION-RELATED) To consider how the performance data may be interpreted by Ofsted, or other external reviewers, and provide further explanatory text
3. (INSPECTION-RELATED) To produce for inspectors a full list of the work undertaken by the CSSH and MASH so they can choose cases themselves
4. To consider keeping – at least for a brief period of time – a record of the inappropriate contacts coming into children's social care. The findings to be discussed on a multi-agency strategic basis
5. Continue to review and publish an updated Lancashire County Council Threshold guidance
6. Following this publication, awareness raising and training sessions to be held within which the appropriateness of referrals with CSSH/MASH can be discussed
7. Ongoing work to continue with other agencies on thresholds and on how to make a referral that will be accepted by children's social care
8. Further work to occur with health colleagues on their understanding of level 4 thresholds
9. Further discussions to occur on a strategic/ managerial level on the promptness of responses from health
10. Other agencies to be supported to contact the CFSWs prior to completing a contact to request a level 3 or a level 4 service
11. For the online referral form to be revised to reduce the amount of time repeating basic information
12. To support the police with being up to date with their completion and sending over of PSRs to the CSSH/MASH
13. To discuss with police, and relevant safeguarding partners, that after 'high' or 'medium' risk PSRs are shared that any further incidents judged to be of 'standard' risk are also shared
14. Develop a formal process for dispensing with consent, supported by legal advice, to ensure that children's day-to-day experiences are at the heart of any such decision making
15. Further work be done to look at the application of thresholds that lead to the higher level of cases going to FIS
16. Across all relevant multi-agency documents to have a consistent description of how/why over-riding consent occurs

17. (INSPECTION-RELATED) It would be useful for work to be done with workers on interview skills, for instance when meeting an Ofsted inspector, or any external reviewer, so that they can more effectively demonstrate the quality of their work

FRONT DOOR

18. Ensure that where there is a recording of involvement with one child in the family this is copied to all relevant children's files
19. Ensure that information can be shared by children's social care with other partner agencies when requested due to concerns about children's welfare
20. Review the use of call-back and consider whether this work can be actioned, recorded, and managed in the same way as other contacts coming into the department
21. Consider recording all PSRs as new contacts on EHM/LCS including the recording of managerial oversight
22. For CFSWs to be notified if a contact is found to be inappropriate by the CSSH/MASH to facilitate timely discussions with the referrer on what further actions to take or to look at what services are available in that community that best meet the families' current needs

CONTACTS

23. Ensure that when decisions are being made to no further action a contact, consideration is given and recorded of the child's lived experience
24. When letters/emails are sent to referring agencies/parents/children a copy of these is stored on the child's file
25. Proforma letters to be reviewed to see if there are more sensitive ways to communicate with families
26. When a contact is received, and appropriate consent is not provided, consideration still to take place on whether this needs further review from the information presented and previous history of the family
27. Ensure that all the work undertaken in response to a contact is recorded in sufficient detail by the workers concerned, including who has been spoken to and their views. The worker responsible is identified in the write up
28. Ensure when there is consideration of further action in domestic abuse situations consideration is given to the previous contacts, the seriousness of this incident and the previous willingness of both parents to address the issues

EARLY HELP

FAMILY INTERVENTION SERVICE

29. When cases initially identified as level 3 are identified as needing another level of support, there to be a timely process for stepping-across
30. Ensure there is a formal system for professional social work support to FIS workers when faced with issues out of their level of knowledge and experience
31. Ensure a consistent approach to recording by managers when new cases come into the FIS teams
32. Ensure there is a unique management oversight for all early help assessments completed
33. (INSPECTION-RELATED) Consider revising the FIS supervision template to ensure there is a section identifying the progress being made to address the families' needs
34. To introduce a standard template on EHM to briefly summarize the position at closure

DUTY AND ASSESSMENT

35. Consider protecting ASYEs from highly complex cases such as leading child protection investigations and court work
36. Ensure a consistent approach to undertaking child and family assessments for children with disability
37. (INSPECTION-RELATED) For an inspection, prepare a briefing for Ofsted and other external reviewers to describe the support services available for those with identified disability needs (i.e. where the child meets the definition of a child in need as defined in the legislation however is not receiving a service from the specialist team)
38. When conducting assessments and making decisions on ongoing support consideration to be given, specifically, to the impact of children not attending school and parental alcohol misuse
39. Ensure that case summaries are completed during, and are updated at the completion of, a child and family assessment. This is to describe the nature of the issues, work undertaken and future plans to meet this family's needs
40. Child and Family assessments which conclude with a step-across to early help to identify what needs to occur if consent to early help support is withdrawn
41. Tasks identified at the end of Child and Family assessments on cases being stepped over to FIS should cover all the relevant issues and these should all meet the level 3 threshold guidance

CHILD PROTECTION

42. (INSPECTION-RELATED) Ensure when cases go to child protection conference, the approach of the local authority is coordinated
43. Consideration to be given to a non-child protection route when there are no concerns about the parent's care
44. (INSPECTION-RELATED) For Child Protection Conference chairs to be clear – if it is decided not to make a child subject to a child protection plan – the decision making behind this on what needs to happen if those circumstances change
45. (INSPECTION-RELATED) Ensure that children are not made subject to a child protection plan so that they can access additional resources alone