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Dear local partnership

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

Between 12 and 16 September 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Probation) undertook a joint inspection of the multi-agency response to abuse and neglect in Salford.[1] This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

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

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

A strong, committed multi-agency partnership in Salford prioritises children living with domestic abuse and promotes a culture of continuous improvement. There is a good understanding of the prevalence of domestic abuse in Salford and this informs strategic thinking. The partnership has a very positive approach to developing initiatives locally to maximise their benefit to children and families within Salford. The Community Safety Partnership (CSP) supported by the Salford Safeguarding Children Board (SSCB) rigorously promotes, coordinates and prioritises the work of all statutory partners around domestic abuse. Improvements to training and learning opportunities are evident, but these have not yet had the intended impact. There remain inconsistencies in decision making and practice by staff across the partnership when working with children living with domestic abuse. In all agencies we found that staff are not consistently confident or sufficiently skilled and knowledgeable in this challenging area of practice.

The partnership is committed to evaluating the quality of multi-agency work, but the performance monitoring arrangements are not yet sufficiently robust and therefore the partnership is not able to understand fully the quality of frontline practice. This leads to a gap between strategic intent and the quality of frontline practice in some critical areas.

Effective responses were seen through the use of early help interventions to meet the needs of some children and their families. Some excellent work was seen in gathering the views of children and young people in children's social care and in early help services. However, deficits in practice were seen in children in need and child protection cases. A lack of effective information sharing and comprehensive assessment of risk meant that the day-to-day experience of the child was not consistently understood by professionals in all cases.

Key Strengths

- Leaders and managers have a good understanding of the nature and extent of domestic abuse in their area, and this informs the development of strategic thinking and planning. It also underpins the Salford commitment to agencies working together to respond to families at an early stage. The partnership has a clear vision and adapts initiatives to maximise their effectiveness within Salford. The partnership has invested significantly in early help.
- Children living with domestic abuse are a priority for the CSP and SSCB and the work includes a key focus on prevention. For example, the 'Real Love Rocks' and 'Black eyes and cottage pies' theatre productions have been delivered across all schools. These initiatives are supporting children to better understand healthy relationships.
- The SSCB drives improved multi-agency working. For example, the board identified a gap in sharing domestic abuse notifications with schools, and this led

to the SSCB initiating, and supporting, a pilot project to share domestic abuse notifications so that all schools now receive this information. The SSCB has also promoted a greater understanding of the Multi-agency Risk Assessment Conference (MARAC) process across the partnership.

- A particular strength across all agencies is the commitment of resources to tackle this issue and a clear determination to remove barriers to effective joint working. For example, the investment in 'the Bridge': a single point of contact for referrals to early help by children's social care, health services, the youth offending service, the police, the national probation service (NPS) and the community rehabilitation company (CRC).
- Innovative approaches such as the young people's domestic abuse meeting, which is a multi-agency meeting for those who have been physically abusive to family members or peers, demonstrate strong partnership working. These meetings enable young people to access appropriate help and support to reduce the risk of their becoming perpetrators of domestic abuse in the future. This work could be strengthened with an assessment of siblings' needs, given the risks presented by these young people. The development of young people's domestic violence adviser role has enabled a more effective response to young people who harm.
- The youth offending service works well with children and young people who are both perpetrators and victims of domestic abuse. Their delivery of the 'Step Up' programme, which educates young people in helping others, demonstrates an effective approach. One young person who attended this programme stated that 'the youth offending service listened to me and took account of my hobbies and what I wanted to achieve and I am now a much calmer person'.
- The prioritisation of domestic abuse and safeguarding by the Clinical Commissioning Group, combined with the commitment of local GPs, has led to increased GP awareness of children living with domestic abuse. Additional training for GPs on domestic abuse was well attended and positively evaluated. As a result, GPs are making more appropriate referrals to the Bridge and increasingly effective contributions to child protection conferences. This is in addition to the Identification and Referral to Improve Safety (IRIS) project in 12 of Salford's practices. IRIS is a GP-based domestic abuse project which focuses on the health indicators of domestic abuse and incorporates a training support and referral programme that includes an enhanced pathway to domestic abuse services. GPs contribute routinely to initial health assessments, including information on children's emotional health and well-being when a child becomes looked after, thus enabling a better of understanding of their needs.
- Timely and effective information sharing between midwives and health visitors supports effective assessment of the child's risk and needs and the appropriate application of thresholds.

- Good awareness of diversity issues was seen in the majority of cases. Good multi-agency work with a specific community was seen, and this enabled effective engagement with children and their families.

- Children's social care routinely make concerted efforts to engage children. Direct work to gather children's views using tools such as viewpoint and three houses was used effectively to understand children's views and much of this work is sensitive and of high quality. It was evident in some cases that there was an appropriate change of focus in planning as a direct result of children sharing their experiences.

- Effective commissioning has led to the development of some good and effective services for victims, such as Salford independent domestic abuse support service, which provides specialised support and independent advocacy for victims of domestic violence as well as for the women's refuge. Housing workers have been trained as independent domestic violence advisers and have been involved in a pilot project with Greater Manchester Police's 'Strive' initiative, where police and housing workers engage with first time victims. These practitioners make follow-up visits with police community support officers to first-time victims when police notifications have not reached a level of concern to be referred to children's social care.

- A pilot project to do preventative work with 4-11 year old girls in schools is also taking place. There are a number of preventative services, such as a group for young fathers. Another example of a good service, 'holding families', is a substance misuse service which intervenes effectively when children are living with domestic abuse. One child stated after the family had received the service, 'Now they [my parents] have stopped arguing and my mum understands how I felt.' However, there are insufficient programmes for those perpetrators of domestic violence who are not subject to a court order. There is still work to do to improve the evaluation of the impact of commissioned services.

- The Bridge serves as an effective single point of contact for referrals into early help and children's social care. Daily meetings and good joint working result in effective information sharing that supports the identification and management of risks of harm to children and young people. For example, the police regularly share domestic abuse notifications with children's social care, health visitors, GPs and midwifery services. Thresholds are understood and well managed. Timely strategy discussions take place, but their impact is reduced as not all health partners are fully included.

- The weekly MARAC is chaired effectively and is well attended by partner agencies and there is a good focus on the needs of children living with domestic abuse, which leads to appropriate referrals to services.

- The multi-agency public protection arrangements identify effectively and manage the risk of harm to domestic abuse victims, including children.

- Strong partnership arrangements are evident between the Bridge and youth offending and probation services. There are good examples of this when court reports are required, with the Bridge working in partnership to ensure that bail conditions of perpetrators are appropriate and focused on the protection of victims.

- Child protection enquiries are completed in a timely way, with good management oversight that is clear and decisive, resulting in the development of plans informed by detailed family assessments. Appropriate interim safeguarding measures are included in the majority of child protection enquires, and these support timely action to keep children safe.

- The police have invested in the training of staff to improve responses to domestic abuse incidents. A particular focus has been on training the neighbourhood patrol officers and neighbourhood beat officers. However, while there was evidence of an improving awareness of the responsibilities of officers when attending domestic abuse incidents, this has not yet led to consistent improvements in practice or the quality of the information recorded.

- Offenders known to the CRC who are also perpetrators of domestic abuse can access a number of interventions through CRC and these are delivered quickly. Good practice was seen the provision of the Improving Relationship Supporting Change programme available to people who did not have convictions for domestic abuse. A pilot programme has just been developed concerning domestic abuse in same sex relationships, which is good practice.

Case study: highly effective practice

The Bridge is effective in enabling children and families to access help at an early stage through a wide range of good early intervention services. Effective information sharing was evident in early help and is improving further with the development of the 0–25 pilot for early help in the West locality, which is supporting the co-location of adult and children's services. Practitioners assess effectively the needs of children and families to ensure appropriate interventions. Direct work tools are used well to gather the wishes and feelings of children. The ethos of early intervention and prevention is family led, which enables the family to engage in services and supports better outcomes for children. The recent adoption of a family assessment form is supporting a more holistic assessment of the family's needs and quicker responses. The 0–4 domestic abuse pathway enables the children centre staff to offer services to families at an early stage to reduce the escalation of needs. The outreach team is a strength.

Practitioners in the outreach team support couples with healthy relationship work when domestic violence has been identified. High quality wishes and feelings work is undertaken with children.

Areas for improvement

- A multi-agency internal audit was coordinated by children's social care on behalf of the SSCB on children living with domestic abuse, and this identified a number of the same themes identified by this inspection. The key agencies have a good understanding of the work that they need to do locally to improve the response to children living with domestic abuse. Findings have been integrated into the children's domestic abuse action plan. The findings from the audit which was signed off by sub groups in June 2016 had not been sufficiently disseminated to practitioners across the partnership, and this undermined its effectiveness.
- The CSP has not effectively developed the performance monitoring and evaluation in this area of practice. The CSP and SSCB recognise that performance monitoring is focused too much on process and needs to develop to focus more explicitly on the impact of services to children and their families.
- The CSP has yet to develop clear success criteria to measure the impact of the work that is undertaken in relation to children living with domestic abuse. In most cases, individual agencies are responding to children living with domestic abuse and their families. Lack of effective performance monitoring and evaluation in relation to children living with domestic abuse from a multi-agency perspective does not enable the CSP to understand fully the day-to-day experiences of children living with domestic abuse or the effectiveness of the response from each of the agencies both individually and collectively. This inhibits the CSP in taking effective action to improve practice and services. The understanding of leaders and managers about the quality of decision making at the Bridge is not sufficiently robust.
- Although some good information sharing was seen at the Bridge and in early help across all agencies, it is too variable at different stages of the child's journey through services. The lack of consistently effective and timely multi-agency information sharing means that assessment of risk is not always based on full information. There are missed opportunities to identify emerging and escalating risks at an earlier stage. In some cases, information indicating escalating risk was known to one or more agencies and was not shared. In other cases, detailed information was shared but did not include key partner agencies, such as adult mental health, so full consideration of risk did not take place.
- Inspectors found a 'positive think' family approach within health, with a clear focus on children and the risks that adults may pose to them. However, health services teams do not consistently have full information on the risk to children and families. Adult mental health services are not consistently being made aware of when there are safeguarding concerns. The inspectorates saw examples of

health records that did not indicate that children were living in households where domestic abuse occurs. Information is not consistently shared with the accident and emergency department. The adult substance misuse service is not consistently aware of the most up-to-date concerns in relation to children and families.

- A range of multi-agency SSCB training and workshops have taken place to develop further the skills and knowledge of frontline professionals, including in the voluntary sector, so that they are able to engage with communities to provide support and reduce risk. The impact of this has been variable for staff from different agencies and has not always enabled professionals to be confident and sufficiently skilled in working in this area of practice. However, health professionals stated that they value this training, particularly for the opportunities to network and develop their understanding of other professionals' roles and responsibilities.
- Agencies do not consistently identify all risks for children living with domestic abuse, nor do they fully assess the impact of domestic abuse on children and young people and their families. As a result, their work with families is not always fully effective. A common feature of cases was that when the victim was no longer in a relationship with the perpetrator, this was seen as a protective factor. Professionals did not always recognise that the abuse does not end when people stop living together and may in fact escalate. This means that risk is not always fully assessed.
- Children's social care and the police sometimes make overly optimistic assessments about the capacity for change within relationships, leading to delays in cases being escalated when risk was clearly increasing. Some cases also showed an unrealistic view of the capacity of victims and perpetrators to comply with written agreements. Examples were seen of victims inappropriately being expected to 'police' perpetrators' contact with their children. Over-optimism also sometimes resulted in plans being continued to be followed when they had been shown previously to be ineffective at reducing risk.
- Responses to serious incidents of domestic abuse by children's social care and the police frequently result in perpetrators being asked to leave the family home. There is limited evidence of work taking place with perpetrators to help them understand the impact of the abuse on their children or safety planning to ensure children's safety.
- Agencies involved in the assessment of victims remaining in abusive relationships failed in some cases to give sufficient consideration to the possibility that the victims may be experiencing coercive control.
- In some cases, contact arrangements were insufficiently focused on the needs of the child and the risk to children living with domestic abuse.

- In some cases, there was insufficient focus by agencies on the risk to children of domestic abuse as these considerations were at times overtaken by other risks arising from the complex needs of the families.

- Examples were seen in cases of the voices and lived experiences of children being less of a focus than the adults' in the management of cases by health services and police.

- The police have developed an assessment process to ensure that the decision making of officers is in line with the training that they have received. While this is positive, inspectors found that there remain inconsistencies in practice. In some cases, significant deficits were seen in the quality of decision making at the police frontline, and further work is required by senior leaders to understand the quality of decision making. Incidents are often dealt with in isolation, with limited consideration given to any previous history of abuse or the wider risks and vulnerability posed to victims. In a number of the cases reviewed, this resulted in a failure to recognise the cumulative or escalating impact of repeated incidents of domestic abuse, leading to an incomplete assessment of risk and a lack of appropriate further action.

- Domestic abuse officers within the public protection investigation unit triage all domestic abuse cases except those completed by accredited officers. The detective sergeant further checks all standard risk cases that have an associated crime file attached to them, thus giving an element of quality assurance. There is, however, no routine dip sampling of all other standard risk cases. Inspectors found examples of standard risk cases that have not been referred to children's social care even when the agreed criteria had been met.

- Delays in the arrest of alleged perpetrators by the police were identified in some cases.

- Health practitioners are underutilised in the Bridge. They are not routinely involved in daily decision making and sharing of information, and in many cases are unaware when a referral is received even though health services are involved with the family. Health services provide information on request. However, there is not a proactive or consistent approach to sharing health information. In some cases sampled, the lack of health involvement meant that the risk assessment was not sufficiently comprehensive, leading to missed opportunities for earlier help.

- Adult mental health practitioners do not consistently ask about domestic abuse. In adult mental health, and maternity, services, the DASH risk assessment is underutilised and does not support the identification of harm relating to domestic abuse when this is known.

- Safeguarding supervision in adult mental and midwifery services is underdeveloped and current systems do not support the process of reflection and

challenge. There is limited senior operational oversight of safeguarding cases and therefore risk is not always shared and the workforce is not fully supported to deal with the complexity of the work in Salford to fully understand and meet the needs of families. Salford Royal Foundation Trust has a robust supervision policy. However, there are inconsistencies in its implementation due to staff shortages.

- There is no system in place to monitor the referrals made by CRC or NPS to the Bridge. Staff from the NPS were not aware of how to save a copy of referral, and this has an impact on effective performance monitoring of the quality of the referral, understanding of thresholds and the effectiveness of the response to safeguard children living with domestic abuse.
- There is a lack of knowledge by health services children's social care and the police about the role of both the CRC and NPS, and how these organisations are critical for assessing and managing the risks of the perpetrator, and most importantly in addressing violence in relationships. At practice level, the support these agencies can offer to safeguard children from domestic abuse is not fully utilised, including their ability to use licence conditions and recall perpetrators to prison.
- Information is not always shared with prisons about the risk an adult poses to children.
- In two of the three cases sampled, there was insufficient focus by CAFCASS on the voice and day-to-day experiences of children as the management of these cases were too focused on the adult.

Case study: areas for improvement

Information sharing is not consistently robust across the partnership and information is not always used effectively to inform the assessment of risk and therefore the response to domestic abuse.

In one case, there were six domestic abuse incidents that the police responded to which were recorded as standard risk and not shared with children's social care, even though there were significant concerns about a young child living with domestic abuse. The lack of child-centred practice led to the child being recorded as being seen and spoken to on only one occasion and a record which simply said that 'the child had not witnessed' the incident. In another case example, it is clear that current interventions and plans were not being effective in improving the child's situation. The plans had been in place for a considerable period of time but had not considered or been informed by all the available information, leading to a cycle of repeated failed interventions which meant that opportunities to change plans based on a comprehensive assessment of need and risk were

missed. This was not recognised until the partnership undertook an audit of the case as part of the inspection. In this case, the perpetrator and victim were tasked with taking action, which was not realistically achievable. A written agreement was in place and although the parent did not attend meetings, their compliance was assumed, which demonstrated an overly optimistic approach in this case. The police took appropriate action in each individual incident. However, there was a lack of recognition that restrictive orders were not being effective.

Next steps

The local authority should coordinate the preparation of a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving Cafcass, NPS, the CRC, Clinical Commissioning Group and health providers in Salford and Greater Manchester Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The local authority should send the written statement of action to protectionofchildren@ofsted.gov.uk by 31 January 2017. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
National Director Eleanor Schooling	Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Chief Inspector

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