Cambridgeshire Threshold Audit - What is it?

The audit was initiated to assure the Safeguarding Children Board that the Cambridgeshire Threshold Document, which was launched in April 2017, has been embedded across the relevant agencies and that safeguarding responsibilities at the ‘front door’ are being fulfilled. The cases selected were audited against the Cambridgeshire Threshold document (2017) and Working Together to Safeguard Children 2015.

60 cases were randomly selected from a list of 2471 referrals which were received by the MASH in Cambridgeshire between 1st September 2017 and 1st November 2017. The cases were selected based on the outcome of the referrals; (i.e. 3 x 20 cases that had; progressed to a Children and Families Assessment or Strategy Discussion; been de-escalated to Early Help; were considered to require no further action (NFA))

Alongside the case audit, an anonymous practitioner survey (Survey Monkey) was sent out to ascertain the views and experiences of the practitioner who refers into the MASH. In total 111 responses were received.

What did we find out from the Audit?

Four main questions were formulated for the purpose of the audit and the overall findings were:

1. Are referring agencies applying the correct threshold levels when referring their concerns into the Multi-Agency Safeguarding Hub (MASH) in Cambridgeshire?

Based on the audit criteria 69% of the applicable referrals in the sample of 57 cases, were considered to have indicated the correct levels on the continuum of need or were referrals from referrers who would have only one route to communicate their concerns for a child e.g. members of the public /anonymous refers. For these referrals, the threshold levels were deemed to have been applied correctly.

Conversely, 31% of the referrals were considered not to have indicated the correct levels on the continuum of need, this was either due to ‘no’ threshold being indicated or the wrong threshold being applied for the information contained within the referral.

- Practitioners completing referrals need to; use the threshold document to guide and support their analysis and conclusion for the level of support needed for the child; and to be confident in recording a threshold level on the joint referral form.

2. Are all of the relevant multi-agency partners being contacted (by MASH) for information at the point of referral to allow for informed decisions to be made?

74% of eligible cases, reviewed from the sample, demonstrated evidence of multi-agency information gathering.

However, over a quarter of cases audited (26%) did not demonstrate evidence of multi-agency evidence gathering.

- MASH practitioners need to consider all possible relevant agencies involved with the family and child who may have vital information which would support and inform their decisions in relation to risk (BRAG Rating) and the service/action needed to support / keep the child(ren) safe.
3. Are agencies making good quality referrals into the MASH?

The audit found that the overall the quality of referrals were variable. For all agencies; some referrals were good, clear concise with a thorough analysis and indication of what the issues were and what was needed to safeguard the child; though there were others that were either very lengthy with irrelevant information or too sparse with little detail.

- Partners and practitioners need to improve the quality of their referrals into the MASH, by being; clear, concise with specific risk and protective factors, having an analysis as to their threshold decision and a conclusion as to what support is needed for the child / family whilst using the correct joint referral form. Additional areas to include would be the ‘consent’ of parents, ‘voice of the child’, sibling’s experiences and any other additional risk assessments completed.

4. Is the MASH making the correct decisions based on the information gained?

The auditors agree with the decision made in 44 out of 51 cases (86%).

Identified Areas of Good Practice:

- There were some referral forms which had additional informative ‘risk assessments’ attached to give a holistic picture of the experiences of the family and child. (e.g. One referral form had a Graded Care Profile (GCP) to support the referral on child neglect; two forms had a CAF (Common Assessment Form) ; Police attached a 102 referral form in terms of an ‘adult at risk’ (about a parent)). **Practitioners should** send additional risk assessment tools to support child protection referrals. (e.g. GCP, Early Help Assessment (EHA), Domestic Violence Risk Identification Matrix (DVRIM), Child Sexual Exploitation (CSE) risk tool etc).

- For the majority of the DASH (Domestic Abuse and Honoured based Violence) forms there was effective management sign off and on one form the supervisor moved the DASH risk level up, given the information that had been given by the practitioner within the form. This shows an effective gatekeeping system. On all of the DASH forms the boxes had been ticked showing that parents/ adults had given consent.

- **Parental consent:** In some cases (65%) parental consent had been gained and recorded on the referral form. There were ‘good practice’ illustrations where practitioners had gained parental consent (children social care, as part of their enquiries, gained consent from parents / a family worker gained consent from both the child and the parent). There was also evidence recorded on two forms as to why consent had not been gained. **Practitioners need** to gain parental consent and to record this on the referrals or if consent has not been gained evidence what the mitigating factors are.

- There was good evidence recorded that ‘non parental consent’, in specific cases, had been overridden for the safety of the child (two Police DASH referrals indicated that mother did not give her consent but this was overridden due to child protection concerns and one anonymous referral the consent was overridden by a team manager within the MASH given that there had been previous similar child protection concerns).

- There was good practice recorded in terms of MASH practitioners contacting agencies (practitioner contacted all of the schools for each sibling /Language line was utilised to speak to the mother, as English was not her first language / education (the school), once contacted by MASH, spoke to the child / the health contact gave reports on all of the siblings within the family)

Areas for improvement

- One referral (joint referral form / police 101 form) ticked the box for Child Sexual Exploitation (CSE) then did not complete the rest of the information required on the form. **Practitioners need** to remember when filling in the joint referral form to complete all areas of the form.
There were only 4 examples (4/11) of the new police 101 form being used on the system. (the new police 101 referral form have a specified area to record ‘parental consent’) and there were a number of joint referral forms submitted which were on the old forms, with old MASH contact details. **Practitioners need** to ensure that they have the correct and most up to date referral forms.

There were cases which arguably could have benefited from agencies being contacted by MASH (one case where the child was at school - education were not contacted, the National Probation service not being contacted regarding a known sex offender, health not being contacted and relevant family members being missed out such as; the child (**voice of the child**) or grandparents (where the child had significant contact)).

On some referrals there was evidence of poor recording, for example one form spelling a child’s name in two different ways and a number of acronyms and medical terms were used without an explanation of what the term / condition is or what that directly means for the child. **Practitioners need** to; avoid using agency terms or if they do explain what they mean in the context of the individual child on which the referral is based; check spellings and do not make inappropriate or derogatory comments.

**What did we find out from the Threshold Survey?**

- The majority of responses to the survey were from practitioners within schools and educational settings (28%); though there were few responses from the voluntary sector and court services.

- 74% of respondents felt that the New Threshold Document for Cambridgeshire had impacted positively on practice, with the suggestion that the document is clearer, supports understanding and takes into account the voice of the child. 15% of practitioners felt that the document had impacted negatively upon practice indicating that they felt that; the thresholds are ‘too high’; the process was too time consuming and left too much to the opinion of the practitioner. There were also 8% of people who felt it had little impact on practice stating that it had not changed their practice either way or that they had not seen or used the document.

- 77% of practitioners felt that the New Threshold Document had assisted their understanding of threshold levels.

- 79% of respondents feel confident in applying the threshold document to their referrals to the MASH

- 74% of people believe that the meaning of ‘consent’ within the Threshold Document applies to four processes from informing the family that a referral is being made, through to consent for services to be offered to the family by Children’s Social Care.

- 87% of respondents are confident in speaking with families when completing referrals

- Just over half (58%) of respondents stated that they are not regularly informed of the outcome of their referrals. Though the findings from the audit show that out of the 39 cases which were regarded as requiring feedback from the MASH, as to the outcome of the case, 30 cases (77%) were recorded as giving feedback.

**Further Information**

Safeguarding Board Websites:


Safeguarding Training: