BOLTON SAFEGUARDING CHILDREN PARTNERSHIP; LEARNING INTO PRACTICE

Strengthening Multi-agency Information Sharing

As part of our continuing commitment to creating a culture of learning and improvement, Bolton Safeguarding Children Partnership (BSCP) want to know more about the effectiveness of current information sharing arrangements across the partnership and the challenges faced by practitioners and managers.

Local multi-agency reviews have consistently identified that sharing and making sense of information about the needs and risks for children and their families can be a challenge. Recent Rapid Reviews have identified when information is not shared and used effectively, it can lead to: -

- Incomplete or flawed assessments and assumptions
- Misunderstanding of child's needs or risk
- Lack of co-ordination, duplication or at worst contradiction
- Ineffective practitioner relationships/silo working

This is the first stage of our 'deep-dive' on this theme, and we are keen to hear your thoughts and practice experiences.

Our Learning

From our local reviews, we have identified that: -

- Understanding of consent and legal gateways to share information with others can be confusing and a barrier
- Not all agencies working with a child and their family are known to the lead professional and engaged in planning and interventions
- Lots of information is collected by agencies but it is not always used effectively or joined up with others to understand what is happening for a child
- At transition points, whether this is between services or across thresholds (step-up/step-down), the quality and timeliness of information sharing is not consistent

"Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children."

Working Together to Safeguard Children 2018

Your Experience

Thinking about your role and responsibility in sharing information, consider: -

- What does the term 'information sharing' mean to you? How, and with whom do you share information in your day to day practice?
- Is this learning familiar to you? Is the learning the same as described? If not, what does this issue 'look like' for you?
- How does local culture, custom and practice, within and between agencies, contribute to this?
- Are there other challenges in information sharing you are aware of; how would you describe them?
- How effective are multi-agency meetings in Bolton as a means of information sharing? Why do you think this?
- What helps/would help information to be shared more effectively in Bolton?
- What action is needed at a strategic or leadership level, and what is needed at practitioner level?

Next Steps

We are seeking the views of practitioners to ensure this is a collaborative approach; share your views with BSCP using the online form link by the **20 November 2020**. We will use the feedback to better understand our local barriers and identify solutions to strengthen multi-agency information sharing. We will ensure action is taken to respond to local findings and share what we have done across the partnership. We have included some anonymised examples on the next page.

Rapid Review – K

K is a toddler and lived with mum, older brothers and sisters. Dad regularly visited the family home but only stayed overnight occasionally. However following the Covid-19 restrictions, implemented in March 2020, he began living in the family home full-time. K's dad was known to use and suspected of dealing drugs. Different agencies, including the GP, police, drug services, probation and education all held information about the nature and likely impact of drug use on K and siblings. A few weeks after dad moved in, K was taken to hospital as it was believed a poisonous substance linked to drug use had been swallowed by K.

The agency reports provided for the Rapid Review identified that there was information known to services that indicated a family with complex needs, including the emergence of possible contextual safeguarding/child exploitation indicators for K's eldest brother. However none of this information was joined up, and opportunities for agencies to proactively share information with other practitioners were not taken. It was clear to the Rapid Review Panel that the children required a co-ordinated multi-agency response to safeguard and promote their welfare; at a minimum delivered through an effective Early Help plan but more likely as children in need.

Rapid Review – Q

Q was a teenager who sadly took their own life. In the months and weeks prior to Q's death, agencies became aware of different significant changes/ incidents likely to have an impact on Q's safety and welfare. Descriptions of Q's weight loss, low mood, thoughts of self-harm and anxiety were known to the GP, Children's Social Care and education. The police were aware that Q was a suspect of alleged child abuse to a peer, mental health and A&E health services were aware of recent thoughts/attempts by Q to end their own life, education were aware that exam stress and aspirations to move onto higher education were placing additional pressure on Q, and also that Q's appearance and presentation had changed.

The Rapid Review identified that while each agency offered help and support in response to Q, they did this in isolation from each other. All the information about Q's lived experience was available and each service offered a level of support and help to the issues that they were presented with; however, the Q's lived experience was not joined up and there is a need to identify where in the local system there are opportunities to support effective early information sharing and promote these to practitioners.