

Ending domestic abuse

Seeing the Whole Picture: An evaluation of SafeLives' One Front Door

The logo consists of two overlapping geometric shapes: a pink triangle pointing downwards on the left, and a teal parallelogram on the right. The word "SafeLives" is written in white, bold, sans-serif font across the teal shape, rotated to follow its angle.

SafeLives

www.safelives.org.uk

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About SafeLives

We are SafeLives, the UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

We work with organisations across the UK to transform the response to domestic abuse. We want what you would want for your best friend. We listen to survivors, putting their voices at the heart of our thinking. We look at the whole picture for each individual and family to get the right help at the right time to make families everywhere safe and well. And we challenge perpetrators to change, asking 'why doesn't he stop?' rather than 'why doesn't she leave?' This principle is applicable no matter what the sex of the actual victim and perpetrator(s) or the nature of their relationship.

Last year alone, nearly 11,000 professionals working on the frontline received our training. Over 65,000 adults at risk of serious harm or murder and more than 85,000 children received support through dedicated multi-agency support designed by us and delivered with partners. In the last three years, nearly 1,000 perpetrators have been challenged and supported to change by interventions we created with partners, and that's just the start.

Together we can end domestic abuse. Forever. For everyone.

We want what you would want for your best friend

- Action taken before someone harms or is harmed
- Harmful behaviours identified and stopped
- Safety increased for all those at risk
- People able to live the lives they want after abuse has happened

Acknowledgements

We thank the Government's Tampon Tax for funding the One Front Door pilot and our pilot local authorities for working with SafeLives on this project:

- Bexley Borough Council
- Norfolk County Council
- North Somerset Council
- North Tyneside Council
- St Helens Council
- Suffolk County Council
- West Sussex Council

Glossary

ACEs: Adverse Childhood Experiences

ASC: Adult Social Care

Brag: Stands for a commonly used colour coding system: Blue, Red, Amber, Green. This refers to the method used in One Front Door to allow agencies to share their expertise and level of concern regarding each family member without sharing detailed, sensitive information. Staff completing this process received training from SafeLives' practice advisors.

CSC: Children's Social Care

CYPS: Children's and Young People's Services

DHR: Domestic Homicide Review. A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Idva: Independent Domestic Violence Adviser

JTAI: Joint Targeted Area Inspection

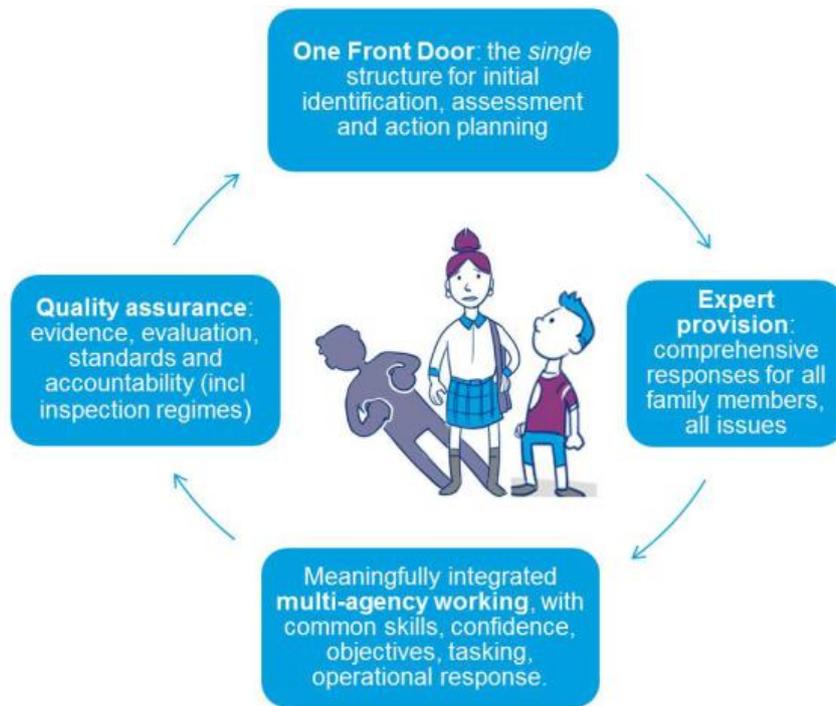
Mash: Multi-Agency Safeguarding Hub

Marac: Multi-Agency Risk Assessment Conference

SCR: Serious Case Review. SCRs are held when there is a non-accidental death of a child or a child suffers life changing injuries.

Executive Summary

“It is effective and it really does work”
Service Lead, One Front Door Pilot Site



Introduction

One Front Door was developed by SafeLives in response to concerns that we are missing early opportunities to help a whole family in difficulty, costing lives and money. Risks to children and adults are not routinely linked, so vulnerable people are missed.

Domestic Homicide Reviews (DHRs) have highlighted these repeated failings as has the recent domestic abuse Joint Targeted Area Inspection which clearly states that professionals were not working together to share information effectively¹. There are gaps in the local and national response; perpetrator responses are rare; and there is often poor knowledge of differing expertise between sectors.

Funded by the Government’s Tampon Tax fund, SafeLives developed the first stage of One Front Door to secure earlier, better help for children and families. In partnership with seven English local authorities – Bexley, Norfolk, North Somerset, North Tyneside, St Helens, Suffolk and West Sussex – between 2016-2019, SafeLives piloted an integrated risk-led ‘whole family’ response to children’s safeguarding and domestic abuse concerns.

Aims of One Front Door

One Front Door brings together a multi-agency specialist team (statutory and voluntary) who can identify the needs and risks of all family members at the same time, making the vital links between the needs of individuals and the families they belong to and offering specialist support to children, victims and perpetrators of abuse. It aims to:

- Identify risks and needs within families experiencing domestic abuse at the earliest opportunity
- Support vulnerable adults and children to get a swift and effective response to address the needs within their family before safeguarding thresholds are met
- Mitigate the impact of Adverse Childhood Experiences (ACEs) on children and young people and reduce future incidence of ACEs

Principles of One Front Door

One Front Door is underpinned by principles which encapsulate the approach needed to meet the needs of families experiencing domestic abuse:

- A transformation of systems, processes and responses
- Better support for children and young people who live in fear
- Creating long term change, not short-term fixes
- Disrupting those that abuse; perpetrators challenged and held to account
- Engaging the 'whole family' means more opportunity to make people safe, sooner
- Families do not operate in silos, and neither must we

One Front Door is a flexible approach which takes account of the local picture and creates an approach that is responsive to the specific needs of families and professionals in each area.

Baseline findings in One Front Door pilot areas

Before the One Front Door approach was adopted in each pilot area, SafeLives undertook mapping work to look at practice and processes within children's social care (CSC) and domestic abuse services, consulted with practitioners and survivors, and audited CSC cases relating to domestic abuse. This found the following challenges to effective multi-agency working on early identification of risk:

Structural issues

- Every area is structured differently, so one size cannot fill all
- Short-term, piecemeal commissioning for specialist services
- Only a third of practitioners understood coercive and controlling behaviour

Services not working together

- Cases aren't managed collaboratively so no one joins the dots for families
- Services are siloed, with poor knowledge of one another's expertise
- Triage is seen as child safeguarding process primarily, making decisions in isolation and only at a high threshold
- Information is not shared cumulatively

The burden carried by the family in need

- Typically, families had come to Mash/CSC four times previously
- Additional needs of adults not considered and complex needs poorly managed
- 62% of children had experienced 4 ACEs+ (compared to 8% for England), yet few cases referenced this
- Following CSC contact, actions focused on the non-abusive parent

“No one understands what is happening for us as a family. We have eight different workers in our house but each one cares about something different.”

Survivor of domestic abuse

The impact of One Front Door pilots

SafeLives practice advisors then worked with all seven sites in England; Bexley, Norfolk, North Somerset, North Tyneside, St Helens, Suffolk and West Sussex, to collaboratively develop a bespoke implementation plan aligned with the One Front Door principles and to support initial delivery. Our evaluation found that the adoption of a One Front Door approach had the following impacts:

Improved structural approaches

“I’ve never worked anywhere it has been so streamlined, it’s so focused and everybody knows what they are doing and everybody is there together in that multi-agency approach. It makes things a lot easier and we’re able to reach a lot more of the victims that come through because of this. It’s a great way to work, you get things done so much more efficiently.”

DA specialist, Site G

- Perpetrator responses were commissioned for the first time in local authority areas
- It resulted in cultural change programmes being initiated in children’s social services
- Ofsted named One Front Door as a positive model in two sites and highlighted faults which would be resolved by its adoption in a third

Improved ways of working

“It’s not just saving time, we’re better risk assessing, we’re helping the families better and certainly from my point of view, the information the police are passing to social care, I think, means the families are getting the services now they should get and I’m really impressed by the way all the partners in the Mash have worked together to get it like this.”

Police lead, site B

- Practitioners were overwhelmingly positive about new ways of working
- Multi-agency work became more collaborative and effective
- There was an increase in parity of esteem between specialist agencies (often voluntary) and large statutory partners which deepened engagement between them
- There was a shift from multi-agency teams administering information to them bringing specialist expertise and meaningful analysis to bear on all information
- In depth analysis in individual sites found:
 - i) Better information sharing resulted in 17% of risk assessments uprated
 - ii) In the first four month of One Front Door implementation, 31% of police contacts progressed to social care assessments from 3% in previous year. It is not clear how much of this increase was as a result of having a better picture of the risks and needs within the family, and how much was due to the lack of alternative outcomes as it was not possible to track the outcome of these assessments.
 - iii) The number of contacts which were not closed with ‘No Further Action’ increased by 25% for the same time periods.¹

“The BRAG rating is really helpful. It makes partners own the process a bit, especially schools. Agencies have to provide analysis, not just information. We need their professional judgement and this helps them to do that. It moves us away from just looking at the incident, actually there’s a bit more of a context around it.”

Social worker, Site B

Challenges of delivery

- Thresholds and statutory timescales sometimes prevented all agencies sharing information which could have highlighted additional risks to the family.
- Early Help interventions did not always have clear referral pathways or service criteria so were not linked into local safeguarding multi-agency hubs.
- Many areas were unable to share data or refused to do so.

¹ This refers to cases which were discussed in the One Front Door meeting. Due to changes in external processes in this site the numbers of contacts during the two time periods were very different and as a result comparing the proportion of cases closed with ‘No Further Action’ would be misleading

Recommendations

- 'No Further Action' is not an appropriate action for families living with domestic abuse. Where CSC thresholds are not met, agencies should work together to identify which other services could provide specialist support to the family.
- Comprehensive Early Help support should be commissioned to ensure that children who have experienced or are experiencing domestic abuse are able to access support before they reach crisis point.
- Domestic abuse is everyone's business, in the same way as children's safeguarding is. All practitioners from agencies working with child and adult victims of domestic abuse should be required to attend cultural change training with a specific focus on coercive and controlling behaviour and responding to all family members.
- A response simply to adult or child victims of abuse is never enough – commissioners should provide a specialist response to perpetrators of abuse so that there are opportunities to change and break the cycle of abuse where applicable, alongside interventions to meet support needs.
- Perpetrators' links to other crimes such as trafficking criminal gang-related activity should be scrutinised by multi-agency professionals.
- Multi-agency hubs should include mental health and substance misuse services. They contribute valuable information and expert analysis and are key to preventing escalation for families experiencing complex needs.
- Where a decision is made in a multi-agency hub not to involve statutory services, identification of a lead professional to co-ordinate is key to providing a joined up response to the needs of the family, reducing duplication and avoiding overwhelming the non-abusive parent with professional contact. Where good relationships between families and professionals already exist these should be utilised rather than introducing someone new.

Next Steps

While the pilot and the evaluation look through the lens of domestic abuse, we feel strongly that the model is applicable to a broad range of linked onward experiences outside the home that can occur in young people's and adults lives, particularly if we don't support them early and effectively enough.

Our next steps are to stress test this approach in additional sites and continue to build the evidence base supporting One Front Door as an effective whole family response. We will look for funding opportunities that will allow us to continue working with our current pilot sites to align all multi-agency responses to the principles of One Front Door. By maximising resources and avoiding duplication of effort the needs of the whole family will remain central to our work.

For more information contact OFD@safelives.org.uk

Introduction

This report presents the findings of SafeLives' internal evaluation of the One Front Door pilot in seven English local authority areas, with Home Office funding. The pilot was completed from June 2016 to June 2019.

Domestic abuse (DA) is experienced by over two million adults in the UK each year, many of them living with children. The consequences of this can be fatal. On average, each year in England and Wales, 100 women are killed by partners or ex-partners and one child dies each week as a result of abuse or neglect, yet services are not identifying and supporting adult and child survivors of DA effectively. Domestic Homicide Reviews (DHRs) and Serious Case Reviews (SCRs) frequently highlight that professionals failed to identify the different forms of risk that were present and how they had impacted on different family members.

A recent SCR stated; "these reviews highlight the consequences for children, young people and their families if professionals are unclear about their responsibilities in this area. More recent reviews have highlighted that information sharing is about more than just passing information from one agency to another. It is about each agency sharing its own analysis of the child and families' circumstances, and ensuring that those who know the child best communicate their understanding of the child's world".² Without this understanding of the whole picture and a shift away from an incident focus, professionals are unable to provide a response that addresses all risks and needs for children and their families.³

Joint targeted area inspections (JTAs) of the multi-agency response to children living with DA in 2018 also concluded that *"the pattern of practice has served its time. We think the system is ready to evolve. Domestic abuse may be endemic, but it is not inevitable and it is possible for prevalence to decline"*.⁴ SafeLives agree that a new approach is required - one which recognises that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to improving the safety and wellbeing of all individuals within a family.

Data shows us that DA was frequently present within families in contact with Local Authority Children's Social Care (CSC). Across England and Wales, DA was the highest single factor identified in Child in Need assessments in 2018, recorded for 51% of assessments.⁵ Despite this, pathways into services providing support for children or for DA remain convoluted and separate, making it harder for families to access the help they need at the right time. Our national Insights data illustrates that 40% of children who were directly harmed by DA were not known to CSC on intake to a specialist DA service.⁶ A review of 293 SCRs between 2011–2014 noted that despite the majority of families being known to CSC, often in relation to DA, only 20% of the children had been the subject of a Child Protection Plan.⁷ This indicates a significant gap in the provision of support for children who are living with DA.

Living in a home with DA is an Adverse Childhood Experience (ACE). Studies have shown a strong association between the number of ACEs experienced before the age of 18 and the risk of mental health problems, chronic diseases, involvement in crime and other poor outcomes in later life, all of which are associated with higher use of health and social care services.⁸ Where protective factors are lacking, these impacts have been shown to impact successive generations of families.⁹ We recognise the concerns some people have around the ACEs framework being used deterministically. In making use of it, we put our emphasis on what services can and should do to mitigate the impact of adverse experiences, rather than making unhelpful judgements about children, and we encourage others to do the same. It is imperative that services are available to prevent or mitigate the harms from ACEs in today's children to improve health and social functioning for generations to come. As Dr Kat Ford from Public Health Wales stated in her blog for SafeLives, *"by viewing the policies and strategies for DVA through an ACE lens we would be able to not just treat the symptoms, but hopefully break the generational cycle of harm and adversity"*.¹⁰

"My children witnessed their Dad hitting me, kicking me, shouting at me, throwing things at me and treating me disrespectfully with utter contempt and hatred. Education stunted. 5 daughters who all ended up in abusive relationships"

Survivor, Every Story Matters¹¹

The One Front Door pilot

Prior to the launch of the pilot, SafeLives carried out scoping work to help understand the response to DA within a number of multi-agency safeguarding teams across England and Wales. We mapped the current models in place and identified examples of good practice and gaps. The key finding was a lack of consistency between areas, with every area structured differently despite many using the term Multi-Agency Safeguarding Hub (Mash). A number of gaps were identified in measurement of outcomes – silo working and professionals not managing cases collaboratively. Extensive case analysis revealed complex webs of interconnected individuals, multiple risks and vulnerabilities within family networks. We discovered that individuals were known to agencies but they were not joining the dots due to systems, culture, caseloads and resources. We also consulted with victims and survivors of abuse, as well as safeguarding and DA professionals. These activities contributed to our understanding of what was working well and what the challenges were, in order to devise an approach that would best address risk and need for the whole family.

In the pilot sites, we found:

Structural faults

- Every area is structured differently
- Short-term, piecemeal commissioning for specialist services
- Only a third of practitioners understood coercive and controlling behaviour

Services not working together

- Cases aren't managed collaboratively so no one joins the dots for families
- Services are siloed, with poor knowledge of one another's expertise
- Triage seen as child safeguarding process primarily, making decisions in isolation and only at a high threshold
- Information not shared cumulatively

The burden carried by family in need

- Typically, families had come to Mash/CSC 4 times before
- Multiple agencies were making interventions with families but not identifying DA (see case study below)
- Additional needs of adults not considered and complex needs poorly managed
- 62% of children had experienced 4 ACEs+ (as against 8% for England), yet few cases referenced this
- Following CSC contact, actions focused on the non-abusive parent

Case study – Chloe

Chloe is 7 years old. She occasionally doesn't attend school and looks neglected. In June 2016 Chloe's mum, Kate placed Chloe with her grandmother and then took an overdose. She was later discharged from hospital with a letter referring her for Psychological therapeutic services. This triggered a referral to Children's Social Care and the decision was made to refer Chloe for an initial assessment. Chloe was visited at school with a view to explore placing Chloe with extended family.

Chloe's father, Jack was contacted to obtain his views. Despite the fact that he was a perpetrator of DA (and had recently been released from prison), no mention of this was made in this assessment. The focus was very much on Kate's mental health. Chloe stayed with her grandmother.

In August, a home visit took place to agree closing the case. Later that month Chloe's aunt called the Mash concerned about her welfare.

During March 2017 there was a series of contacts with agencies including:

- A silent phone call from Kate to the police. The police attended the address and reported that Kate had bruising to her eye but she did not want to co-operate with police
- Kate presented at A&E with anxiety – Chloe was with her at the time
- Kate was referred to Marac but there was no record of the case being heard
- Other records show that Jack received a caution for an assault on Kate

Between 2014–2017, there were 47 opportunities to identify this family needed support. Because we didn't join the dots and look at the whole picture for each individual in the family, opportunities were missed. Chloe's father Jack was invisible throughout, neither being challenged or offered support to change.

The impact of living in an abusive household for most of Chloe's life may have devastating consequences for her emotional and physical wellbeing. One Front Door gives professionals the opportunity to work together, sharing information and expertise, to understand and help the whole family as soon as possible.

The One Front Door approach

As a result of this scoping One Front Door was developed. One Front Door is a risk-led whole system approach which is much more than a model or process. One Front Door is part of a pathway of support that relies on agencies who are motivated and working together towards the same outcomes. One Front Door was developed by SafeLives out of a recognition that families, and the individuals within them, have interconnected risks and needs which need to be addressed in a collaborative ‘Whole Family’ way.² The overall ambition for the One Front Door approach is to create a single access point for supporting people who may present with a number of different needs, including but not exclusive to DA, mental health, substance misuse, housing and child or adult safeguarding.

Given the scope of system change needed to reach the full ambition of One Front Door, we decided to pilot an integrated referral pathway only for children’s safeguarding and DA concerns. Although this represents the very first stage of the overall vision for One Front Door, in this report it will be referred to as the ‘One Front Door pilot’.

Aims

- By removing the current duplication of effort and data sharing by professionals, One Front Door is designed to facilitate pre-emptive intervention by a multi-agency specialist team able to identify risk to all members of a family at the same time, as depicted in figure 2 below.
- By taking a holistic approach to addressing needs One Front Door aims to mitigate the impact of ACEs in this generation of children and young people and reduce the incidence of ACEs in generations to come. Existing research has suggested that preventing ACEs in future generations could reduce levels of incarceration by 65%, violence victimisation by 57% and high risk drinking by 35%.¹²

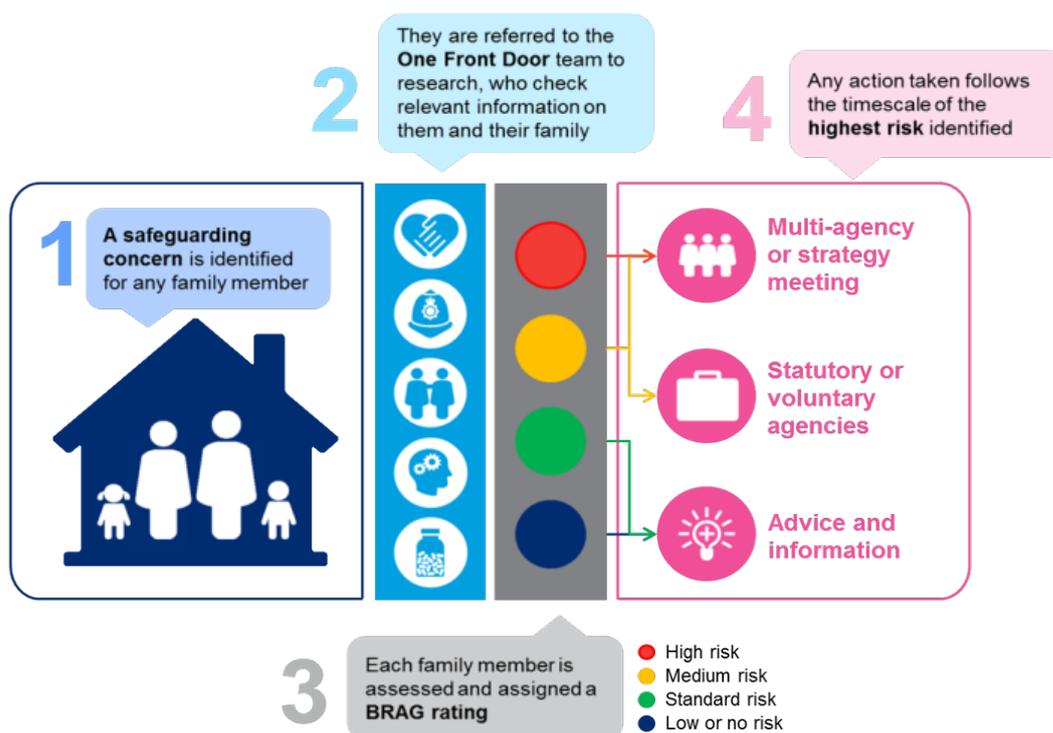


Fig. 1 The One Front Door process

² In this research, collaborative working is defined as ‘Hub organisations working together to integrate child safeguarding and domestic abuse’.

Differences between One Front Door and Multi-Agency Safeguarding Hubs

The One Front Door is not just a Multi-Agency Safeguarding Hub (Mash). When first introduced to the One Front Door approach, some sites felt that their Mash was performing well and was already close to a One Front Door. The One Front Door differs from a Mash in a number of ways:

- 1) It aims to identify the risks and needs of *all* members of the family, including connected individuals who could pose a risk of harm. Many Mashes only identify the risks and needs of the individual for whom the referral into the Mash is made. Given that many Mashes are led by Children's Social Care, this is often referrals for children whose needs are assessed without reference to family members including potential victims and perpetrators of DA.
- 2) One Front Door takes a cumulative approach to risk assessment, ensuring that the history of incidents of DA are considered in context, with a real attempt to understand the whole picture of what life is like for the whole family. An incident focus has been noted to result in short-term responses which "make it harder for professionals to see the bigger picture and history of abuse within the family setting".¹³ It also makes it harder to see connections between incidents and people outside of the immediate family.
- 3) In One Front Door, all agencies have an equal voice regarding the initial risk rating which determines the next steps for a case. Where local statutory thresholds for information sharing are met, it is shared between all agencies rather than just being provided to CSC/ASC to aid their decision making. Along with information sharing on known individuals, agency representatives will share their expertise based on available information to provide a fuller picture of the situation for family members. It is this expert analysis of the information being shared that enables the multi-agency team to assess risk and need accurately, and the sooner this is done the better.

SafeLives' initial scoping work showed that even in the most comprehensive Mash, after sharing information, actions mainly relate to the referred child rather than the wider family. In a Mash, if social care thresholds are not met, no actions are implemented. In a One Front Door, actions should be put in place by any agency, to address the risks and needs of any family members, not just the children or young people. Agreement on a lead agency for follow up will facilitate a joined up response to the family, avoiding duplication and managing the demands on family members engagement during what may be a very difficult time. This approach requires a common purpose around supporting the whole family that transcends individual agency perspectives to provide consistent and holistic support to families. As site representatives at a One Front Door workshop stated:

"Everyone owns One Front Door, that's why it's different from Mash"
One Front Door national workshop, September 2018

Differences between One Front Door and the Troubled Families Programme

One Front Door is 'upstream' of the work done by local Troubled Families Programmes. Put simply, the Troubled Families Programme is the intervention work while One Front Door is the way that support needs for any family member, not just children and young people, can be identified at the earliest opportunity.

Troubled Families works primarily with families who have multiple high cost problems, and have high use of reactive services, where risks and needs are evident to professionals and a multi-agency response is needed to effect change. One Front Door aims to improve the whole family response when one family member is known to be at high risk, for example ensuring that there is a response to the needs of children and the perpetrator of abuse as well as the victim when high risk DA has been identified. The One Front Door approach also brings agencies together to identify a wide range of risks and needs for families where issues are just starting to emerge and individuals may not yet be accessing the services that can support them to overcome these issues. Working collaboratively and sharing information much sooner builds the whole picture for the family so that interventions can be offered earlier, before they escalate to the point of meeting statutory thresholds for social care intervention. One Front Door brings together a wide range of statutory and non-statutory agencies to ensure that there is a breadth of professional expertise that can assess risk to all family members.

One Front Door is expected to add the most value to families where social care thresholds have not yet been met, which can be the case even where high risk behaviours have been identified. This is in comparison to the most recent Troubled Families report which highlights a reduction in the numbers of looked after children and children on child protection plans within their programme cohort, the highest threshold interventions for CSC. This is a key example of how the approaches focus on different ends of the spectrum of need for families, although it is inevitable that there will be some crossover in cohorts. Some families who go through the One Front Door may meet Troubled Families criteria; however, many will not be as entrenched in service use and other less intense, shorter, possibly bespoke interventions will be appropriate to prevent escalation of risk and support multiple needs for the individuals within those families. What the two approaches have in common is the importance of working with the whole family picture –

always and throughout the journey for that family. Below are two cases from One Front Door sites that exemplify the potential difference between Troubled Families and One Front Door cases.

Troubled Families – Kira

Kira's family are well known to services, including CSC. Her older half-siblings had social care involvement when they were children and one older sister is known to have a history of offending as a teenager, leading to her imprisonment at the age of 18. Concerns had been raised that Kira's Dad Mark behaved in a sexually inappropriate way towards his step-children who as a result leave the home to live with relatives.

Police and CSC log multiple incidents of DA by Mark towards Helen over the following years including one with Kira and new-born brother Olly present where they have to physically remove a drunk Mark from the home. Records show that Mark is open to probation for a period of time. The family are later linked with a child sexual assault investigation (victim and suspect are extended family). During this investigation, 14 year old Luke discloses he had been sexually assaulted by the same suspect a few years previously. CSC do not take further action following any of these incidents.

Low school attendance by Luke and Kira, and long-term unemployment of parents eventually brings the family to the attention of the troubled families programme. Support is provided to the family for 14 months, primarily supporting Luke with his behaviour at school and eventually onto a mechanics training course. There is evidence of close working with Education. Once Olly is attending nursery, Helen is supported in activities to get back into work. Although case notes document that Mark is 'verbally unpleasant' to professionals there is no evidence that Helen receives support around DA or that Mark's behaviour is challenged.

After this intervention DA concerns continue. Helen and Mark separate and Mark begins a new relationship with Stephanie, with whom he has two more children. Stephanie also reports multiple incidents of DA including a rape by Mark to Police, resulting in discussion at Marac. Mark's two families are not connected by professionals and no information from Marac is logged on records for his older children. School and Police share concerns about Kira exhibiting sexualised behaviour, resulting in a social care assessment, though again no action is taken.

If One Front Door had been in place the family could have received a joined up multi-agency response much sooner. Addressing Mark's abusive behaviour at this stage could have prevented Stephanie from experiencing DA and sexual violence and reduced the ACEs impact on the children. If Helen had more 'space for action', Kira's early sexualised behaviour may have been noted and addressed earlier.

There were many missed opportunities to intervene with the family before Troubled Families became involved, and it appears they were very focused on school attendance and worklessness, rather than other issues within the family.

One Front Door – Ivy

Teenagers Ivy and Alix become known to CSC for the first time after their Mum, Eleanor, reports escalating harassment from her ex-partner Glen who repeatedly makes threats to harm himself and circulate intimate photos of Eleanor if she does not communicate with him. The two girls had witnessed Glen's abusive behaviour before the end of the relationship and there is also evidence that Glen had made contact with the girls to get to Eleanor and they are affected emotionally by this.

Eleanor is a successful professional with financial resources to access a private therapist for Ivy for depression and self-harming. She had been 'managing' the harassment for several months before she made any reports to police and it is noted she and her daughters had moved house several times in a short space of time. One Front Door professionals take a whole picture approach to assessing risk and note the escalation in incidents and deterioration of Ivy's mental health after information shared from health reveals she had been brought to A&E after taking a deliberate paracetamol overdose. CSC are identified as the lead professional for follow up - they encourage Eleanor to consent to an Early Help assessment and provide advice about seeing a referral to CAMHS for Ivy. Education are made aware of events so they can keep an eye on Ivy and Alix at school and report any future concerns. Eleanor reports she will refer herself for support from DA specialist services at Outreach level.

This family would be very unlikely to have come onto the radar of Troubled Families, with Eleanor using her informal support network, not contacting the police for many months and paying for private therapy for her daughter's mental health needs. One Front Door was able to bring professionals together as soon as the abuse became evident to look at ways to offer support to Eleanor and her two children and ensure that where universal services did have contact with the family (e.g. school), that they had the required information to give context to any changes in behaviour that they may note in future.

SafeLives' One Front Door Pilot sites

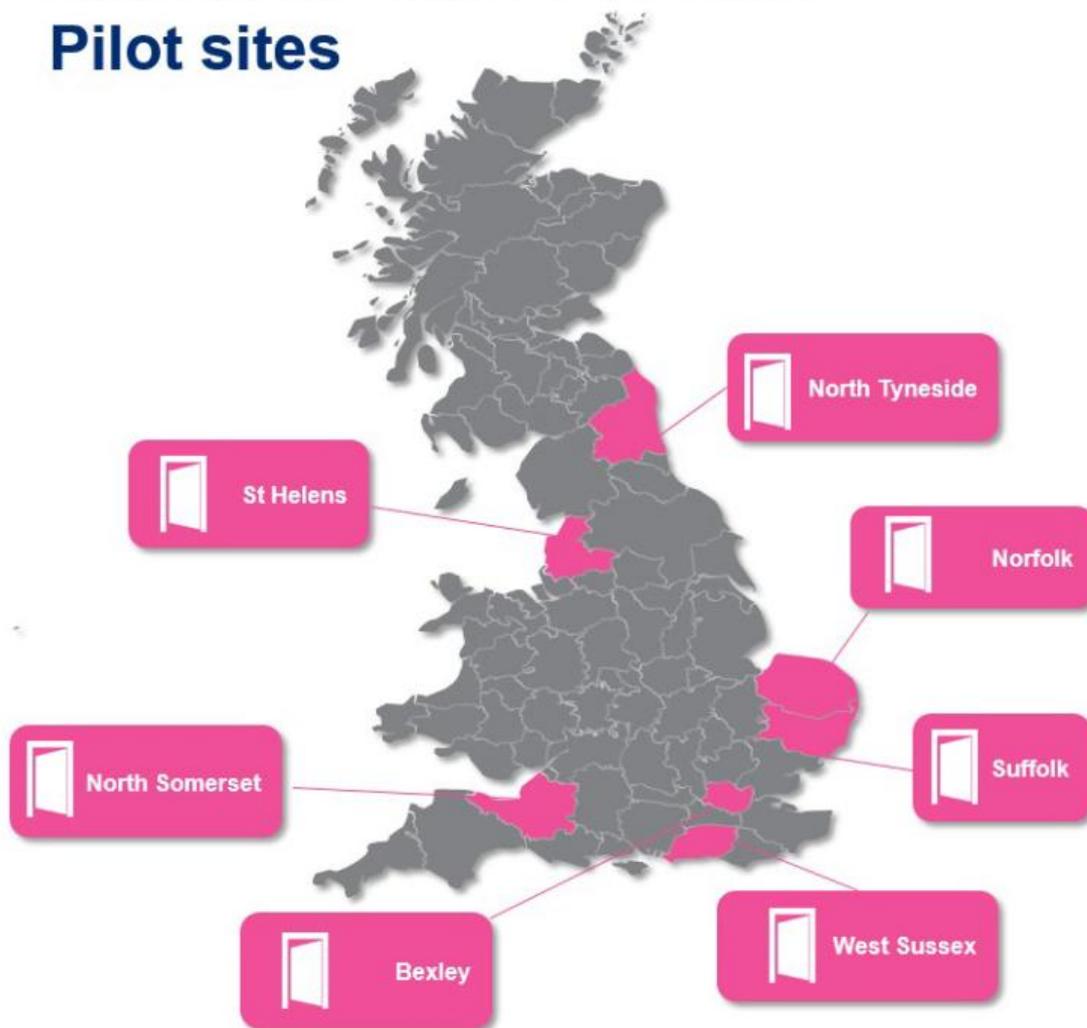


Fig. 2 Map of One Front Door pilot sites

Pilot areas

The pilot was undertaken in seven areas in England: Bexley, Norfolk, North Somerset, North Tyneside, St Helens, Suffolk and West Sussex. These areas are shown on Figure 2 above. The seven sites vary in their composition, from an outer London borough, to a small urban borough with higher than average levels of deprivation, to large counties made up of multiple urban areas.

Pilot Implementation

Following selection of the seven pilot sites, and development of a Privacy Impact Assessment with independent legal advice and the Information Commissioners Officer, a practice advisor with expert knowledge around DA, safeguarding and partnership work was allocated to each site to provide intensive support over a period of several months in the development stage of the pilot. The start of the twelve months of support for each site was staggered, with the intention that two sites would be in the intensive initial stage at any one time. This scheduling allowed for early lessons to be incorporated into the approach at later sites; however, it did mean that some sites had a wait of eighteen months before their development work began. During this time, key stakeholders from each area were kept informed and engaged in the project through attendance at quarterly project board meetings and bi-annual national workshops to share learning and ensure that sites were given the opportunity to collaborate on the process of making SafeLives' vision a reality.

The plan was for the same development and research activities to be completed at each of the seven sites. When work began at the first pilot site, Site A, additional time was factored in to allow for an extended period of preparation work. This was to allow time for practice and evaluation tools to be developed but also to help mitigate the impact of unexpected challenges as the approach was applied in a real world setting for the first time. Site A began a significant

transformation of the whole Local Authority structure which resulted in a long period of upheaval while One Front Door development work was being attempted, and ultimately prevented implementation of their bespoke One Front Door action plan at the intended time. The intention was for SafeLives to return to the site once the restructure was complete and new processes were embedded, however this took longer than anticipated and the implementation stage of the pilot did not begin before the end of the evaluation period. Learning from Site A was used when development work began at the next sites. This included prioritising buy-in from all partners early on, ensuring they were all aware of the pilot taking place, and understood their own roles in implementing change.

The table below shows the key areas of focus during the development phase and their purpose:

Activity	Purpose
Delivery of presentations, attending strategic groups, facilitating workshops for professionals who will lead or deliver the One Front Door pilot	Engaging key stakeholders with the pilot project and sharing information on what it will entail for them
Liaison with local services	Mapping local service provision and identifying opportunities to meet service user groups
Partnership working review through a range of methods such as staff surveys, interviews and workshops	Understanding the current multi-agency culture and provoke thoughts about change management. Identify what is working well and where the challenges are in terms of collaboration between agencies within the multi-agency response to safeguarding and provide support with strategies to improve this
Case reviews of families known to children's social care	Understanding current local practice, links and gaps between high risk DA and child safeguarding and child protection, identify areas for development and build on areas of good practice
Initial analysis of data to predict impact on volume	Recognising concerns about volume increasing and supporting areas to plan for and manage any changes
Development of policies to underpin partnership working including information sharing agreements	Ensure practitioners are confident to share information appropriately and within GDPR legislation and that risk assessment is consistent across agencies. Support with strategic direction to support multi-agency working

An individual implementation plan was developed with each site which took into account the local context and aimed to build on existing strengths and good practice. There are key consistent elements of the One Front Door across each of the sites; however, there are also differences in the way the approach was piloted in each site as a result of the bespoke offer. As shown in Fig. 1 the original intention for this first stage of the pilot was for all safeguarding and DA concerns relating to adults and children to have the One Front Door approach applied to them. It quickly became apparent when work in the first sites began that CSC and adult social care (ASC) processes were very separate in many areas and aligning them would not be possible given the time available to implement this first stage. Site G was the only site where adult and child safeguarding concerns were received in the same place. The decision was made to reduce the scope of the pilot to focus on the pathways for DA and children's safeguarding in the first instance.

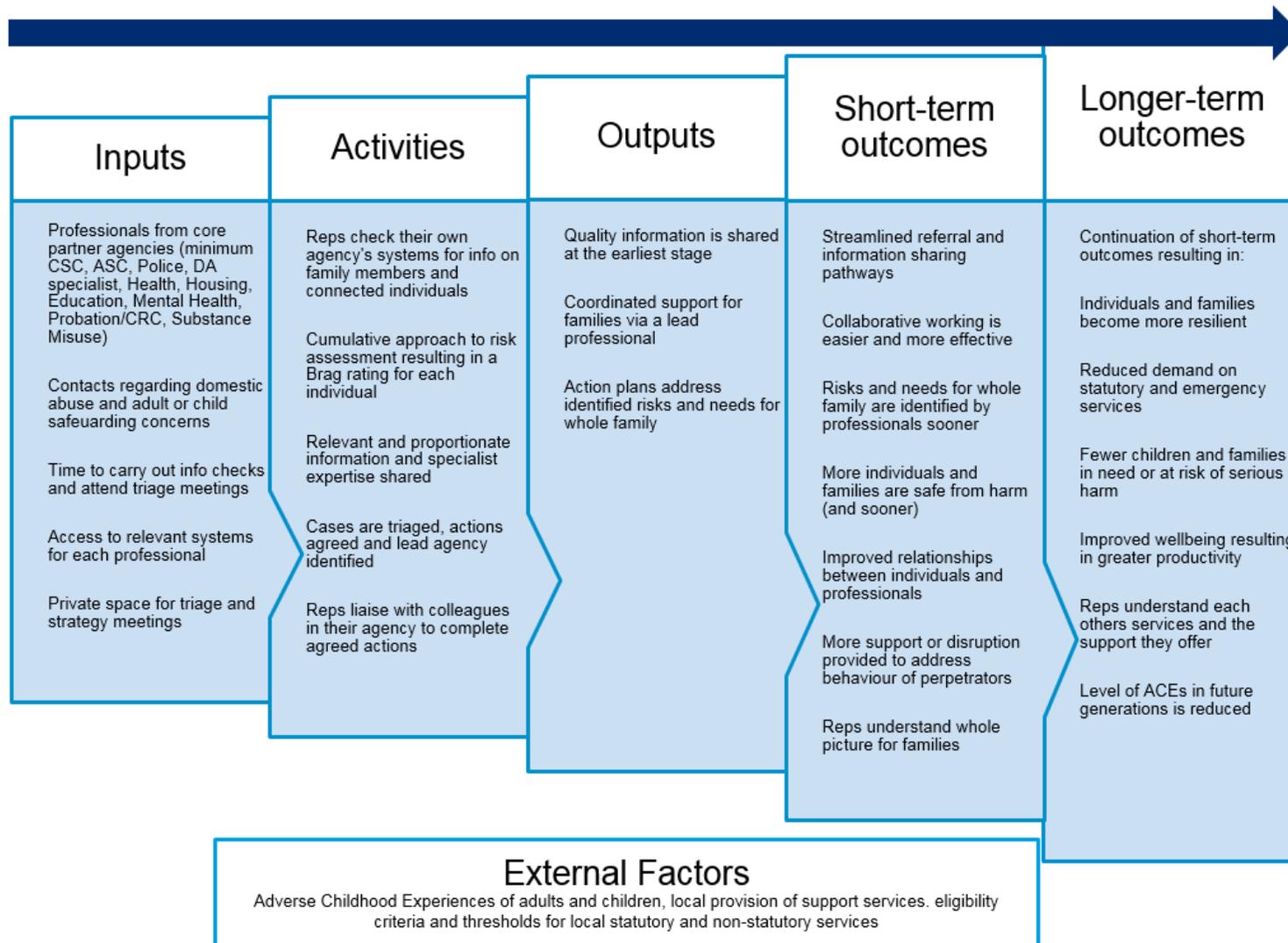
Privacy Impact Assessment

SafeLives developed the Privacy Impact Assessment to help One Front Door sites:

- Facilitate compliance with data protection obligations and the reduction of the risks of harm to individuals through the misuse of their personal information;
- Share information about living individuals;
- Disclose information about individuals to organisations or people who have not previously had routine access to that information;
- Use information about individuals for a purpose it is not currently used for, or in a way it is not currently used;
- Make decisions or taking action in ways which can have a significant impact on individuals; and
- Process information as part of the One Front Door model that may raise privacy concerns as it is more sensitive (e.g. criminal records, protected characteristics, gender identity, known health issues and other information that people would consider to be particularly private).

What did we think the impact of One Front Door would be?

The Logic Model shows the anticipated outcomes from the first stage of the One Front Door.



Evaluating One Front Door

Methodology

In order to understand the picture in each site prior to SafeLives' involvement, a number of activities were completed to provide a baseline of processes and perspectives in each local area. These activities were:

- Mapping of existing referral pathways and service provision
- Consultation with survivors of abuse
- Consultation with practitioners working in the area
- Auditing of CSC cases relating to DA

With the exception of the survivor consultation, these activities were repeated once sites had implemented their pilot for comparison with baseline findings.

Existing referral pathways and multi-agency working arrangements were mapped and compared to the key features of a One Front Door to support identification of what was working well and what we were worried about. This process involved consideration of the decision-making points for referrals and looked at which agencies were involved in decisions. The provision of specialist DA services and availability of support and interventions specifically for those perpetrating abuse were also mapped to understand what support was available for any family member identified to be at risk throughout the process.

SafeLives sought out the views of people with lived experience of DA to understand their perspectives on accessing support in each area. These activities were completed in five of the seven sites. Survivors were invited to take part in focus groups (n=4) and one to one interviews (n=9) to share their views. Survivors were very positive about the support they had received from DA specialist services, however the cohort were sourced through local DA services and focus groups were completed with existing groups of survivors who were engaging well. Attempts were made to reach a wider range of victim voices through dissemination of paper and online surveys however response to these was very low, and the views of survivors who had not engaged with local DA services are not represented.

Practitioners working in the same five sites were also asked for their views on multi-agency working within the area prior to any changes being made to local processes via an online survey. In total 261 practitioners responded to this survey, with representation from the range of One Front Door agencies varying across the sites. Overall the majority of responses to the surveys came from CSC (33%), Health (15%) and Police (11%) practitioners. Respondents required some knowledge of the approach and surveys were therefore circulated to attendees of workshops delivered in each area to raise awareness of the work SafeLives were doing as part of the pilot. This meant those who completed the survey were more likely to have an interest in multi-agency working and be engaged with the pilot. Interviews were also completed with practitioners from the One Front Door agencies who were identified as key stakeholders to understand their experiences of working in and with social care teams around safeguarding.

A total of 19 pre-pilot case audits were completed on CSC cases, using the local case management system. The purpose of this was to analyse how each area was managing contacts relating to DA and to identify key points for development. Cases were selected by the sites and the selection criteria requested were complex cases known to have multiple contacts relating to DA or featuring significant additional needs. Where case studies are presented in this report as examples, the names used are all pseudonyms.

Case audits were also reviewed with regard to ACEs to build a cumulative picture of the adverse experiences of the children within each family. The assessment was based only on information recorded on the CSC case management system so only ACEs that were known to professionals were reviewed.

The adverse experiences we looked for were:

- Sexual abuse
- Physical abuse
- Verbal abuse
- DA between anyone in the home
- Parental separation
- Mental illness of anyone in the home
- Alcohol abuse by anyone in the home
- Drug abuse by anyone in the home
- Incarceration of anyone in the home

The Welsh Adverse Childhood Experiences Study (2015) found the following relationships between experiencing four or more ACEs prior to the age of 18 and a number of health harming behaviours:

People with 4+ ACEs are...
4x more likely to be high risk drinkers
6x more likely to experience/cause teenage pregnancy
6x more likely to smoke e-cigarettes or tobacco
6x more likely to have sex under the age of 16
11x more likely to smoke cannabis
14x more likely to be a victim of violence
15x more likely to commit violence against others
16x more likely to use crack cocaine or heroin
20x more likely to be incarcerated
...in their lifetimes than people with no ACEs

We recognise the concerns some people have around the ACEs framework being used deterministically. In making use of it, we put our emphasis on what services can and should do to mitigate the impact of adverse experiences, rather than making unhelpful judgements about children, and we encourage others to do the same.

Findings – site mapping prior to One Front Door

Mapping of local services showed that the short term and piecemeal nature of commissioning contracts for specialist DA and Sexual Violence (SV) services was an issue in a number of sites. In Site A the recommissioning process coincided with the start of development work. Due to uncertainty faced by frontline DA specialists and service managers regarding the future of their jobs, and a number of staff leaving for new roles, this flux in provision impacted the ability of the SafeLives practice advisors to build relationships with these vital partners.

It was common for there to be several providers delivering DA services within some areas, leading to a lack of clarity amongst other professionals about where to refer those experiencing abuse for different types of support. Where there were multiple providers this caused difficulty for practice advisors in identifying how to integrate them into One Front Door, as there would be many services holding relevant information on those who had experienced abuse. In Site D, DA specialists supporting victims at all levels of risk were employed by the local housing service and were not highly visible to other services, leading to confusion about the support they could offer.

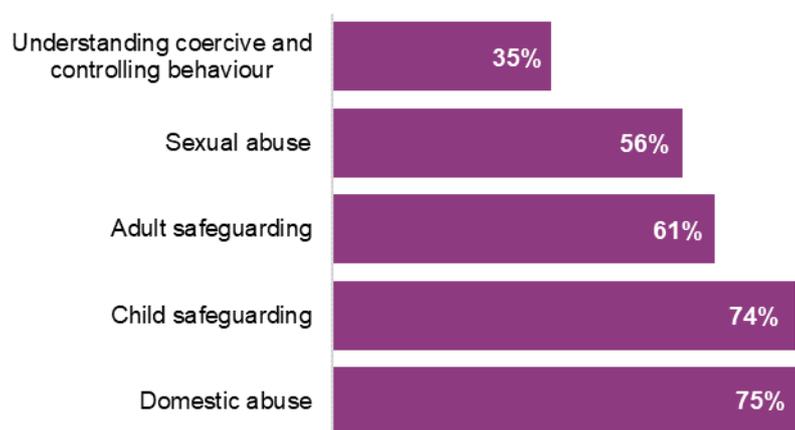
Survivors raised similar themes across the sites regarding barriers to disclosure and accessing support, with many survivors citing fear that they would lose their remaining control over their situations if professionals became involved. Many shared they had felt uninformed about decisions made about them by professionals and did not feel they were able to express their views or have a say in what happened to them. Participants with children described a “very real fear” that they would be removed if they asked for help, exacerbated by tactics perpetrators had used to make victims feel they were bad parents and prevent them from asking for help.

“Once it starts, that’s it, the ball keeps rolling. You can’t stop. Once you tell someone, that’s it”
Survivor in focus group, Site B

Understanding of domestic abuse

Many survivors had encountered professionals who they felt did not recognise their situations as abusive or were dismissive of their disclosure when they were not experiencing physical abuse. As a result they had not been offered help. Among practitioners who responded to our survey, three quarters (75%) reported accessing training on DA in the last two years but only slightly more than a third (35%) had received training on coercive and controlling behaviour, indicating this is a gap in knowledge that needs to be addressed in order to improve the response to those who do not fit the image of the typical victim, or who are experiencing non-physical abuse.

Training received in the last two years by respondents to practitioner survey in five pilot sites



The case of Abdul below highlights how even though professionals had concerns that he was a victim of abuse there was no intervention until the situation escalated. This could be a result of misconceptions by professionals about the type of abuse experienced by men. Luke Martin, a leading professional working with male victims of domestic and sexual abuse, and an approved Respect trainer, recently wrote in a blog for SafeLives; *“all professionals need to have an understanding of men’s experiences of abuse and recognising abuse perpetrated by women”* in order to improve outcomes for all victims and their families.¹⁴

Understanding it's abuse and accessing services

For some survivors it had also taken a long time to realise their own situation was abusive. Several survivors stated they felt that not seeing themselves reflected in DA campaigns or posters about local support services which often depicted victims of physical abuse had contributed to this.

“If it's not physical you can think it's not abuse”

Survivor in focus group, Site D

Survivors reported confusion about what support was available to them and how to access it. Participants in all sites reported receiving conflicting information from professionals which had left them feeling unsure about how to access support and this had resulted in approaching a number of organisations several times before they found effective help. Peer support from a drop-in was described as invaluable in terms of finding out where to access help with a particular issue and get information about which services were the best, with one participant stating:

“My Idva saved my life but my peer support group healed me”

Survivor, Pilot site

“When you're scared of the authorities, you're scared of losing your children or you're scared of what you are going to say or scared from the fact that you've been told a million times that you are crazy and you finally talk to someone else and they say 'you're not crazy, I get it', it's an important bond and then you can say 'right well this is how you link in to these services, this is how it works”

Survivor describing peer support group

Multi-agency working arrangements

Although some of the pilot sites had an established Mash and others did not, there were broadly similar responses across sites when practitioners were asked for their opinions on multi-agency working. Common strengths were viewed as agencies having a shared understanding of both risk and needs and knowing and understanding the goals of working together. There was felt to be a commitment from all involved agencies to make their arrangements work. Despite this, practitioners reported they often did not receive all the information necessary on cases and did not feel that agencies co-operated to provide information. A lack of understanding of the referral criteria and thresholds for each other's agencies was identified as a frustration in the majority of sites. It was commonly reported that certain agencies had different interpretations of when it was necessary to share information, and what was 'proportionate' to share at each time:

“What constitutes a safeguarding risk within one dept. of Mash is not always agreed as such a risk within another and professionals do not always have their specialist knowledge taken into consideration”

Practitioner survey response, Site E

Whether or not there was a Mash in place, the process of triaging contacts and referrals was viewed as a primarily CSC led process, with other agencies asked to supply information. Outcomes were limited to decisions on whether a threshold was met for CSC to take action regarding the children only. Non-CSC practitioners reported they received feedback infrequently on cases where they had raised concerns and lacked confidence that all the risks and needs of children and young people were being identified. Multi-agency working was viewed as positive once families were open to CSC and there were formal arrangements like core groups and child in need meetings in place. Some non-CSC practitioners who had acted as lead professional at Early Help (EH) level reported difficulties in bringing professionals together to work collaboratively.³

“They seem to work together better for high threshold cases, but this is often too late - we need to work together better in early intervention”

Practitioner survey response Site F

³ Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Department for Education (2018) Working Together to Safeguard Children

Case Study - Abdul

Abdul may have been the victim of DA by his wife for several years. It was not until his health had deteriorated significantly due to alcohol use, and he was hospitalised with injuries from a physical assault, that his case was referred to a Marac and the dynamics of abuse were thoroughly investigated by professionals.

Abdul and his wife had refused consent for CSC involvement. But if information had been shared, the whole picture may have shown that the threshold for safeguarding intervention had been met. Life for the three boys living at home could have improved much sooner, and Abdul could have received appropriate support.

In some sites there were multiple multi-agency meetings, managing risk for a range of issues. Site G considered their multi-agency arrangements to be a strength; however, practitioners reported there was often duplication in terms of families being on the agenda for discussion at more than one meeting, while the agency representation at each meeting was broadly similar. In the Site E Mash, despite being based in the same office, some practitioners reported there was little face to face communication between representatives from different agencies and several made reference to 'departments' within the Mash, indicating the team was still divided by specialism and members did not share an identity.

Survivors told us that in their experience they didn't feel that communication between professionals in different agencies was effective, with many expressing frustrations at having to re-tell their story each time they spoke to someone new.

"I had to go through multiple different agencies, and it was literally just going in and going through, explaining everything, the whole story again. And that is very, very draining"

Survivor in 1-1 interview Site F

"It takes you back to day one basically, reliving that"

Survivor in 1-1 interview Site G

Case audits evidence that CSC was often making triage decisions in isolation based solely on the information they held, with little evidence of information being requested from other professionals that may have been involved in the case. In the Mash sites there was evidence of some initial information sharing but often only between CSC, Police and Health or a DA specialist. Wider agencies might only be asked for information where an issue was known, e.g. substance misuse services being contacted when substance misuse issues are already known about and even then, it was not routine (see case study 'Michelle'). Additional needs of adults involved with the family other than primary caregiver were often not considered during assessment. There was poor recognition and management of risk where the complex needs of DA, substance misuse and mental health were present for any of the adults. These three intersecting factors are associated with increased risk of harm to families and were frequently highlighted in serious case reviews in relation to siloed working and lack of inter-agency working¹⁵.

Case Study - Michelle

Concerns were raised with CYPS (Children and Young People's Services) for Michelle's two children Louis and Carly six times over 18 months. The first contact occurred after a DA incident where Michelle had been assaulted by her partner Rob. CYPS were made aware of concerns regarding Michelle's mental health, and alcohol use by both parents in addition to the DA in the first contact. When subsequent concerns were raised, the mental health and substance misuse services known to have been working with Michelle were not asked to share information to aid decision making. Several contacts were closed with 'No Further Action'. The case was Brag (risk) rated Red when an incident occurred putting Louis and Carly in significant danger and at this point proceeds to a social work assessment. CYPS did not appear to consider how the three risk areas of mental health, substance misuse and DA were intersecting and what this meant for the home lives of Carly and Louis.

Case audits completed in Sites D and E showed good evidence that DA risk assessments such as the SafeLives Dash risk assessment were being used routinely by police and information on the score was shared when CSC were notified of concerns. There was less evidence of this in the other sites. In cases where the victim of abuse does not have a good understanding of DA, using risk assessment tools can provide an opportunity to open the conversation about experiences within a relationship. Use of Domestic Violence Protection Orders/Notices (DVPO/N) and where applicable Domestic Violence Disclosure Scheme (DVDS) applications can also offer an opportunity to engage the victim and/or the perpetrator in services to break the cycle of continuing abuse, but were rarely utilised in the cases we looked at.

Where a victim was assessed as being at high risk of serious harm or murder and a referral was made to Marac it was often observed that Marac and Mash/CSC processes were not joined up, with information shared at the Marac not being recorded on CSC systems. When future CSC referrals were received, practitioners did not have access to this relevant information when making decisions. Case audits and practitioners revealed it was common for contacts relating to high risk DA to have been closed by CSC well before they were heard at Marac. Following information sharing at Marac, additional concerns were identified for children in the family and there would be a re-referral to CSC. This duplication added to the volume of contacts CSC received and delayed the offer of support to the family.

Identification of risks and needs for all family members and connected individuals

Almost all the cases audited featured multiple CSC contacts relating to DA incidents that were risk assessed in isolation. On average the family had come to the attention of CSC/the Mash four times previously. Information from different referrers was rarely viewed cumulatively to develop a fuller picture of what life was like for children within the families. None of the cases referenced ACEs or evidenced that they had viewed the concerns raised for the children with an ACEs lens to identify support needs. Site G was the only site where pre-pilot case audits evidenced routine consideration of the voice of the child during assessments; however this only applied once the threshold for CSC assessment had been met.

The qualitative data gathered during the audit process was coded to aid identification of key themes and comparison of characteristics of the cases. This revealed that 24 of the 39 (61.5%) children in the scope of the audits had experienced at least four ACEs before the age of 18. This is significantly higher than the findings of an English ACEs study where 47% of respondents had experienced at least one ACE and 8% had experienced four or more¹⁶. In addition to DA, the most common documented ACEs were parental separation (90% of cases), parental mental health issues (55% of cases) and parental alcohol misuse (50% of cases). Our findings show a higher level of need for the adults and children within families where there is DA who come into contact with CSC compared to the general population.

Adverse Childhood Experiences (ACES)



As a result of missed opportunities to identify risks and needs, actions were not put in place to support the family following the referrals to CSC. As little changed for the family there were further referrals down the line. In Site B a re-audit of the four pre-pilot cases was completed after 12 months. In two of the cases there had been no further contact with CSC, but in the other two, after several contacts were closed with 'No Further Action' (four and two contacts respectively since each case had last progressed past referral stage), the children had been placed on Child Protection plans which had been open for almost 12 months at the time of the re-audit. This indicates that the concerns had been allowed to escalate to the point where the children were considered at serious risk of harm, despite opportunities to intervene sooner.

Whether there was a Mash in place or referrals were dealt with on a single agency basis, CSC had the final say on case outcomes and actions were only put in place where the threshold was met for intervention in relation to the needs of the child/parental ability to meet this. As one practitioner survey respondent stated:

“The Mash still feels CYP-centric, sometimes feels that risks to adults not given same priority of need. Would like to see a greater parity and recognition of roles of all agencies.”

Practitioner, Site E

Case audit data showed that following the latest contact, actions were recorded for the children in 11 (58%) of audited cases. Actions relating to the needs of the victim of abuse were recorded in 13 (68%) of audited cases, this included signposting or referral to DA services; however, there was no information on whether support was accessed. Only one case evidenced an action for the perpetrator and this did not address their abusive behaviour but was in relation to substance misuse.

Case Study - Nicole

Nicole's daughters, Megan and Melissa, had numerous CSC interventions during the eight years they had been known to services. Actions in the Child in Need and Child Protection plans are focused on actions Nicole is expected to take to protect the children, including attending a DA pattern changing course. There was never a requirement for any of her abusive partners to engage with services to address their abusive behaviour and despite ongoing abuse after the end of the relationship, the perpetrators of abuse appear invisible to services once they are no longer living in the same property as Megan and Melissa.

The actions and outcomes following CSC contact were disproportionately focused on the non-abusive parent. The recorded outcomes tended to focus on the non-abusive parent engaging with services and taking actions to 'act protectively' without recognition or provision of support to overcome the barriers caused by the experiences of abuse. Victims living with DA know that they are at greater risk if they leave - often the perpetrator will threaten to kill them or harm themselves or family if they do leave. Living with fear cannot be underestimated in terms of impact on the decisions victims make that professionals may perceive to be unsafe or unwise. The onus was also on the individual to engage with the service, rather than for the service to engage the individual. Audits also revealed examples of the non-abusive parent being tasked with passing on messages or getting the perpetrator of abuse to engage with services (see case study 'Samantha'). There were very rarely actions implemented that aimed to address the perpetrator's abusive behaviour or challenge to address this by professionals. While some areas did not have a formal perpetrator programme, this should not be a barrier to professionals having conversations that nudge behaviour and attitudinal change while working with the family. Evidence from the Drive project has found that one in four perpetrators of high-harm and serial abuse have more than one victim¹⁷. This highlights the need for professionals to change their focus and ask 'Why doesn't he stop?' rather than 'Why doesn't she leave?'. The JTAI also recognised this was likely to shift the risk elsewhere:

“Perpetrators often present a continued risk to their partners and children. If agencies fail to address the perpetrators' behaviour, the perpetrators can leave their home without any follow-up action and repeat the behaviours from afar or in a new relationship”¹⁸

Case Study - Samantha

When Samantha's children, Alf and Chloe, are supported on a Child in Need plan, Samantha is engaging with the process and is keen for support with issues around her housing and managing a new born baby on her own after ending her relationship with Pete, who had been abusive for a number of years. After Pete fails to attend a number of meetings with CYPS the Child in Need plan puts the responsibility to contact him and persuade him to engage with the process on Samantha, as well as asking her to ensure he does not have contact with Chloe.

Support from SafeLives during pre-pilot audits

SafeLives staff embraced opportunities to address this imbalance. The practice advisor in Site E reported that social workers and police officers had given feedback that they lacked confidence to challenge perpetrators and were concerned they may increase the risk to the victim of abuse. In addition to a successful funding application for a pilot perpetrator programme in this area, workshops were delivered by SafeLives to CSC and Police staff. There was huge interest from practitioners in attending the sessions.

“I think the key to changing their minds was having a DA practitioner on site that gave a different perspective about perpetrators and informed them about the challenges perpetrators faced e.g. around ACEs awareness, and responses from perpetrators which were linked to their life experiences”

SafeLives Practice Advisor

Sessions focused on the dynamics and strategies used by perpetrators, and the impact of failing to hold perpetrators accountable for their behaviour. This included apparent collusion by professionals, the likelihood perpetrators may go on to be abusive in future relationships and reinforcement of messages like ‘if you tell anyone you’ll lose your children’. Feedback from attendees was that the sessions gave them a much better understanding of the impact of non-physical abuse tactics and more confidence around engaging with perpetrators of abuse and working with families who want to stay together. A senior stakeholder within Site E fed back that without SafeLives’ involvement this shift in perspective would not have happened.

Survivors in all the sites also recognised that perpetrators often appeared invisible, with many giving examples of the lack of response to the perpetrator’s abusive behaviour by police and other professionals being ‘taken in’ by their behaviour. This had contributed to their reluctance to disclose, and the belief it would either make no difference or make things worse. Survivors felt there was not enough provision of behaviour change programmes and public awareness raising campaigns aimed at perpetrators. As one survivor stated:

“I’m not the problem. I want help for him to stop”

Survivor, Pilot site

Findings – barriers to implementing One Front Door

It quickly became apparent that in order to implement One Front Door, a significant amount of culture change from the statutory organisations would be required. It was vital that sufficient time was allowed for the Practice Advisors to support sites through this change management. Potential sites were identified based on the appetite for testing transformation by the Children's Services executive team in each area. This was vital to ensuring access to CSC however it did mean that partner agencies were not brought on board until later, despite the key role they would play in implementing change. Sites also had to put a lot of trust in SafeLives, as they committed to the project before knowing what it would look like.

Engagement at an early stage from all agencies at a strategic and operational level was important to ensure the implementation of the One Front Door approach. In order for all agencies to understand their role in implementing the One Front Door pilot it was crucial that strategic engagement was present in planning from the beginning. Strategic leaders were invited to the practitioner workshops in the early stages of SafeLives' work at each site. Their response varied, with demand at one site necessitating separate sessions for strategic and operational leads while at another it was noted that no 'policy makers' had attended the offered sessions.

Governance was a crucial factor in determining the success of the pilot across the sites. Good governance structures combined with strategic buy-in to the approach led to relatively quick progress and implementation taking place. A clear governance structure meant that when issues did arise there was a clear escalation route to the correct level of decision makers who were in a position to resolve them.

The sites had different governance arrangements in place before the One Front Door project. Where existing structures were not in place and new arrangements were not implanted for the pilot this impacted on the pace of progress towards implementation. The SafeLives practice advisors identified these groups as important for meeting key stakeholders from partner agencies to introduce them to the pilot and its aims. Links with existing fora such as Local Safeguarding Children/Adults Board and the Domestic Abuse Partnerships were key to reaching strategic leaders across a wide range of local services at once.

“I think without that planning and making sure that the governance was clear, without having included such a wide network when getting together the One Front Door, it wouldn't have happened”

Strategic leader Site F

Governance for One Front Door differed across the sites. Some sites utilised existing governance groups such as the Mash strategic or steering groups, with One Front Door becoming a standing agenda item. Others established new operational and strategic boards with clear Terms of Reference which set out the membership and remit of the group. Flexibility in the frequency of meetings in relation to need at each stage of their pilot contributed to the perceived effectiveness of this approach, as the group did not meet if there were no developments to discuss.

Site D had one high level local board with a very broad remit around safeguarding, community safety and health, but did not have any oversight of One Front Door and practice advisors were not invited to attend any of the meetings during their time on site. There were difficulties in reaching agreement on where the governance of the project should sit, and this contributed to delays in decision making which meant that the site was not ready to implement changes before the end of the funding period.

Multi-agency buy-in was required at a suitable decision making level to be able to drive the project forward. Having a breadth of agencies represented at a strategic level also helped One Front Door to feel like a shared project rather than one owned by social care. Practice advisors highlighted that having close links with a local lead in the correct position of seniority made a significant difference to their ability to maintain progress in implementation. It was felt that this role needed to be someone above team leader level, but close enough to operational delivery to understand and influence daily practice. Challenges were faced in identifying the right person for this role at two sites, and several sites were affected by high levels of staff turnover in both leadership and operational roles. The lack of continuity halted overall progress and required repeated 'selling' of the approach to the new post holders. Linked to this was the issue of priorities for sites changing, either due to new leadership or external pressures, including feedback from Ofsted to address high volume and delays in decision making.

Representatives from the sites who attended a One Front Door workshop in September 2018 reflected that they had found the flexibility of the approach beneficial. This allowed sites to adapt the day to day operational working to fit their local picture, while retaining the key One Front Door principles. Sites were also able to make adjustments to their processes, for example in order to enable wider involvement of agencies in the information sharing process. This flexibility is reflected in the differing models of implementation within each site.

Within the One Front Door teams, two key roles were identified as contributing to the successful development of the pilot. One site had a dedicated project manager, while the others were reliant on managers who were already stretched in terms of capacity. The project manager was highlighted as improving that site's ability to take a longer term view of the project, pre-empt issues and keep the pilot growing in the right direction. The site with the project manager was the first site to begin exploring expansion of the cohort of referrals that would go through the One Front Door process and will shortly widen the criteria to concerns around DA from any source. The role of One Front Door coordinator was also identified as key to ensuring efficiency regarding processing of incoming referrals coordination of the Brag process and sharing of information as per identified risk level. This role involves more than just administration and could involve chairing One Front Door meetings and responsibility for recording the actions and outcomes that are agreed.

Stability within partner organisations was required during the development and implementation stages of the pilot. Retendering of DA services impacted relationship building with DA specialists delivering support at all levels of risk in sites A, E and F as a result of their uncertainty about the future and the loss of staff as they moved elsewhere. In Site F this delayed the start of pilot implementation and also raised issues around access to historical DA service records once the new provider took over, though this was overcome with support from the local commissioner. Access to historical Marac records was also an issue in Site B after a new DA provider was commissioned. Contracts for provision in Site E have recently been awarded to the third provider in a short space of time, raising the same issues. Due to uncertainty over recommissioning, the perpetrator programme in Site G did not accept new referrals for several months, meaning there was no formal perpetrator support available during this time. Short term commissioning of DA services is common and will likely impact all the One Front Door sites in the future, raising questions regarding capacity for staffing One Front Door and information sharing. Incorporating One Front Door into the local DA strategy, and maintaining links with local leads, will be important to ensure these issues are anticipated and overcome.

Findings - what does an effective One Front Door look like?

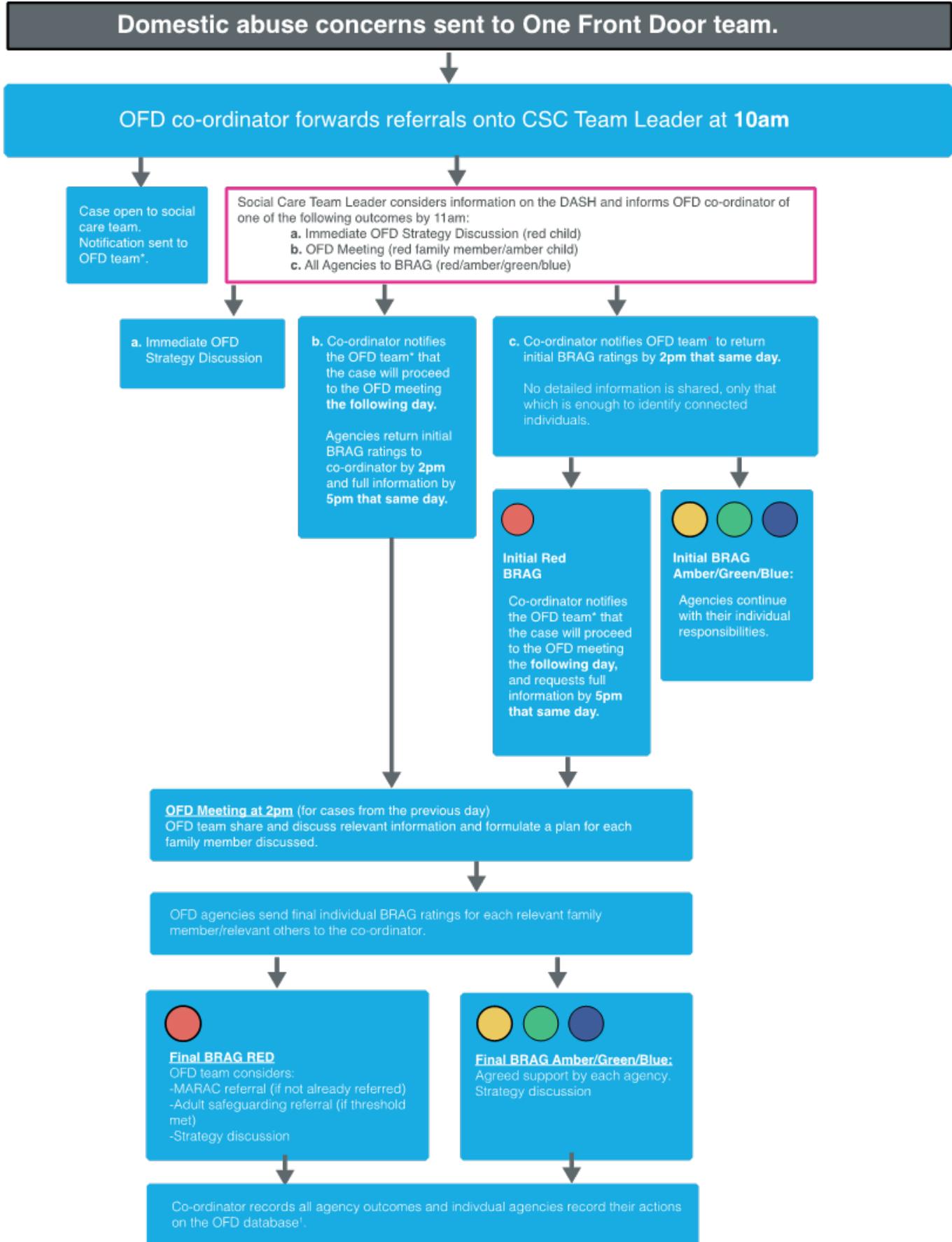
Four of the seven pilot sites put their implementation plans into practice before the end of the evaluation period. SafeLives worked with each site to develop bespoke implementation plans which gave careful consideration to the structures, provision, volume and priorities of the local area. This led to models that worked with the unique circumstances of the areas but that were still designed around the principles and aims of One Front Door.

In order to compare the sites we have focused on how closely their new practice is to the model One Front Door and, where data permits, to what extent it meets the One Front Door objectives of an integrated referral pathway, collaborative multi-agency working and earlier identification of risks and needs for all family members and connected individuals.

Integrated Referral Pathway

For this first stage of the pilot the focus was on integrating the pathway for contacts relating to DA where children were known to be in the family. The ambition is for a single point of contact for any safeguarding concern by any agency, members of the public, self-referrals, or for friends and family members; with and without consent, depending on the level of risk.

The first stage of One Front Door, as it was implemented in Site F is illustrated in Figure 4 on the following page.



***Agencies in the OFD Team:**
Co-located services: CSC, Police, domestic abuse service, Health, Housing, Early Help **Non-co-located** Education, High Impact Families, Mental Health², Probation³, Substance misuse⁴

¹OFD database to be in place in June 2019; ²Mental health, currently only provide information; ³Probation, join on conference call if there is a non person; ⁴Substance Misuse, go to some meetings and will not BRAG Red if person is unknown or no longer in their service.

Figure 4: The first stage of One Front Door in Site F

As a starting point, all four of the sites which reached the implementation stage identified the notifications of DA from Police as a suitable cohort for the beginning of their pilot implementation as this was felt to be a manageable initial volume level while practitioners became confident in the new processes. This pathway is reliant on Police being called and recognising abuse, and then identifying children connected to the victim or perpetrator. Not all groups report abuse to the police at the same rates, and the limitations of this initial pathway in terms of supporting these groups are acknowledged. There is also potential for children to be missed if responding officers take an incident focus or do not recognise the impact of abuse on children. Where children have previously been removed from the home, police may not recognise a need for information sharing with CSC, however a record of DA can become pertinent later, for example in relation to future pregnancies or if children may return to their parents' care. It is important that police forces provide appropriate training for all staff responding to DA, including identifying coercive and controlling behaviour and the impact of this on children within the home to ensure CSC are informed of all relevant contacts.

Although contacts related specifically to children, once received by the One Front Door team all family members were assessed for risks and needs. The One Front Door risk assessment involves applying a colour coded risk assessment rating (Brag rating⁴) either individually to each family member, or combined into one whole family Brag. Where it was implemented, the process of each agency providing a Brag rating for each family member was recognised as beneficial for a number of reasons including a prompt for practitioners to consider what they knew about the perpetrator where this had not been a common occurrence before. Not all sites did provide individual Brag ratings for all family members, but stated they did consider all family members in their single Brag rating. SafeLives' position is that providing individual Brag rating gives clear evidence that the risks and needs for all family members have been considered, and this will highlight where intervention is most needed. If all family members are being considered this should not make a significant difference to the time taken to Brag a case. Overall the Brag rating process was viewed positively. One social worker highlighted how Brag rating from all partner agencies helps to ensure that the whole picture is considered:

“The BRAG rating is really helpful. It makes partners own the process a bit, especially schools. Agencies have to provide analysis, not just information. We need their professional judgement and this helps them to do that. It moves us away from just looking at the incident, actually there's a bit more of a context around it”

Social worker, Site B

Non-social care practitioners reported that the Brag rating process contributed to the feeling that the voices of all agencies were on equal footing, as a Red or Amber rating from any agency would impact the next step for that case. The contributions of experts from a wide range of agencies meant that decisions were no longer made based on just the presenting issue, but by taking all known concerns (for example health or substance misuse) into consideration as part of the holistic risk assessment process. This was vital to ensure that risks and needs were identified at the earliest opportunity. Practitioners reported that they felt confident to challenge the Brag ratings of statutory partners and justify their ratings following training on Brag rating and assessment of severity of abuse that was provided by practice advisors. In Site E another sign that One Front Door was a shared process was that meetings were chaired on a pre-agreed rolling basis between agency representatives, however other sites retained either Police or CSC leadership.

The Brag rating also contributed to confidence around information sharing. Practitioners reported that this, along with the One Front Door information sharing agreement that was developed with each site helped them to feel confident to share information that was relevant and proportionate to the identified risk levels within each family.

The Site A baseline triage process looked at all police incidents of DA involving vulnerable adults as well as where children were present and while numbers were extremely high, this did reveal children who would otherwise not have been known, and provided reassurance that a thorough response was being provided to vulnerable people in the area. This suggests that an integrated pathway for concerns relating to adults and children would improve the identification of risks and needs and would still be a recommended goal for pilot sites to work towards.

After six months of implementation, Site F were the only site ready to expand their One Front Door cohort to include children's safeguarding concerns relating to DA from any source. Site B had widened their criteria to include all Police notifications of concern relating to children but did not yet think they had capacity to include referrals to CSC in their meeting.

⁴ Brag rating is a colour coded risk assessment framework where Red is high risk, Amber is medium risk, Green is standard risk and Blue is Low risk. Some pilot sites did not apply Blue ratings to any family where there was evidence of domestic abuse

Collaborative Multi-Agency Working

The core agencies that must be represented in One Front Door are Children’s Social Care, Police, Domestic Abuse, Health, Education, Housing and Substance Misuse. As shown in the table below, some sites have also included Early Help, Probation, Youth Offending Services (YOS), Mental Health and Child and Adolescent Mental Health Services (Camhs) and have found that these representatives have contributed valuable insight and expertise where they have been part of the team. Site B also had input from the local Marac co-ordinator as the new DA provider does not have access to historical Marac records which were felt to be a useful source of information.

	Site B	Site E	Site F	Site G
Children’s Social Care	✓	✓	✓	✓
Police	✓	✓	✓	✓
Domestic Abuse	✓	✓	✓	✓
Health	✓	✓	✓	✓ (0-19 and primary care)
Education	✓	✓	✓	✓
Housing	✓ (co-located but not in daily meeting)	✓	✓	✓
Substance Misuse Services		✓ (if individual Known)	✓ (if individual Known)	✓
Early Help			✓	✓
Probation		✓	✓ (remotely if individual known)	✓ 1 day p/w and YOS
Mental Health	✓	✓	✓ (info only)	✓
Camhs				✓

Of these four sites, the two demonstrating the widest agency representation are Site F and Site G, both of which did not have a Mash at the point of being chosen to take part in the pilot. The Mash in Site G was implemented shortly before One Front Door development work began on site, while Site F utilised this development work to support the development of a long term One Front Door approach to multi-agency working arrangements. The wider representation at these two sites is representative of the increased ability and commitment to make structural changes from those sites who did not already have established multi-agency arrangements in place, compared to those who felt their existing arrangements were working well. Despite this, all four sites reported benefits from adopting One Front Door once changes had been made, and where external inspections have been made the positive feedback helped to cement these changes.

Practitioners in all sites reported that co-location with colleagues from the partner agencies had brought improvements, recognising that being able to communicate face to face resulted in better information sharing, saving time compared to emailing or trying to reach people by telephone. One health practitioner stated she had previously felt like she was dealing with cases alone when following up after DA incidents, but within One Front Door she was able to see how other agencies were responding, and had a “better understanding of what was going on after the incident, with less back and forward” (Health rep, Site G).

Even in those sites with an existing Mash where practitioners had been co-located for some time, the One Front Door process encouraged practitioners to work more collaboratively. The Practice Advisor working in Site E noted a visible difference in the Mash office at the start of their micro-pilot as it was possible to see staff physically approaching colleagues from other agencies to discuss cases which had not been observed during the preparation phase. This suggests that while co-location is beneficial, it is not sufficient in itself to facilitate effective multi-agency working. One Front Door brings a shared purpose to collaborative working, with all practitioners having a shared understanding of what good looks like from the perspective of each family they work with, rather than focusing on their own agency’s purpose or policy. The level of collaboration within One Front Door, “allows people to share their knowledge and skills to problem solve for each other’s cases” (DA specialist, Site F) rather than just passing on information.

When agencies were not all co-located, or were not represented in the One Front Door this resulted in clear gaps. For capacity and resourcing reasons a number of agencies only participated in the discussions for cases they were actively working with, and did not attend or dial in on days where this did not apply. This often applied to Substance Misuse Services, Mental Health and Probation/CRC. Their input was highly valued when they were present. Observations of One Front Door meetings revealed numerous examples where information came to light, or expertise was shared that changed the picture for the family, which would have been missing if the referral were discussed on a different day. In Site E a Police Sergeant reported that missing agencies limited how well the approach had worked, describing it as “*time consuming, not just in the meeting, but also chasing other agencies not co-located in the Mash. These agencies are not always dialling in to the meeting, when they thought [it was] not relevant, however their professional opinion/advice would have been useful*”. As noted above, parental mental health issues and parental

alcohol use were among the most common ACEs documented for the children in the pre-pilot case audits, so the inclusion of these agencies in the One Front Door will be vital for implementing actions to address these needs for adults and reduce the impact on associated children.

Case Study – Rhiannon

When a contact came into Site F regarding Rhiannon and her young daughter Lola, One Front Door agencies identified numerous risks. Both Rhiannon and her partner Callum were Brag rated Red, with Lola given an Amber rating. Representatives from CSC, health and the DA service all raised concern about Rhiannon's mental health in the meeting where detailed information was shared between agencies. There was no mental health representative in the meeting but by chance a senior mental health practitioner was visiting the team to learn about the One Front Door approach and as a result they supported an urgent referral to mental health services, and offered an appointment to Rhiannon at her local health service the following day. The MH service response to this experience was incredibly positive. They believed this case highlighted for them how positive the One Front Door approach was. In their view, Rhiannon was extremely vulnerable, had not been identified by services previously and had clear risks around mental health. They felt it was an example of being able to offer a service to someone who would not normally have been identified or reached by MH services, and this in turn also assisted in the protection of Lola.

There is a degree of flexibility in the One Front Door approach to ensure that sites can work within their local structures and maximise multi-agency involvement. Soon after their initial implementation date, Site F modified their timelines to ensure that representatives from children's schools could be invited to the One Front Door meetings for non-Section 47 cases, as their input from daily contact with the children was important for information and implement actions and follow up with the child and non-abusive parent. School staff were enthusiastic about getting involved, with one member of staff from a local school describing the process as "the best thing ever". Input from those who know the children well is vital, as there are few opportunities to directly capture the voice of the child in this initial decision making stage. Case audits highlighted good practice within Site G and Site B in seeing children alone and utilising Signs of Safety tools such as the Three Houses⁵ to gather the wishes and feelings of children and young people during social work assessments.

The pre-pilot practitioner feedback indicated that there was a common concern that One Front Door would be very time consuming, and the quote on the previous page from the police representative in Site E reflected their experience when trialling the process for six cases. Practitioners in sites B, F and G where the pilot became business as usual, stated that after some initial adjustments the process was very efficient and resulted in timely information for decision making being available without the need for time consuming chasing of professionals in partner agencies:

"I've never worked anywhere it has been so streamlined, it's so focused and everybody knows what they are doing and everybody is there together in that multi-agency approach. It makes things a lot easier and we're able to reach a lot more of the victims that come through because of this approach. It's a great way to work, you get things done so much more efficiently"

DA specialist, Site G

"It's not just saving time, we're better risk assessing, we're helping the families better and certainly from my point of view, the information the police are passing to social care, I think, means the families are getting the services now they should get and I'm really impressed by the way all the partners in the Mash have worked together to get it like this"

Police lead, Site B

As Ofsted highlighted, "the ability to share information quickly and effectively is critical to whether or not agencies are able to work together to spot risks, triangulate a picture of a problem and diagnose a solution".¹⁹ One Front Door implementation to date shows it to be an effective way to facilitate this process.

Health representatives reported the most difficulties in information gathering for the volume of cases due to the complexities of their systems and having to check several information systems across health providers for every family member and connected individual. This was less of a problem for other agencies that had a single information system to check and often would only hold information on a few family members.

5 The three houses is a [signs of safety](#) risk assessment tool designed for use with children and young people

Practitioners from a range of agencies in the implementation sites reported that as a result of working more closely with the DA specialist their knowledge had improved around DA, understanding of the Idva role and awareness of all agencies having a role in addressing DA and safeguarding. DA specialists within One Front Door in several sites reported that practitioners from other agencies based in the same location, such as housing, would approach them for advice on their cases where DA was present, suggesting that the improvement in DA response was starting to spread further than their immediate One Front Door colleagues. In addition to day to day improvements, one strategic partner reflected that their involvement with the pilot had changed the way the area would approach their next DA strategy:

“By having the One Front Door and being part of the early discussions we can now say ‘we have these high risk high end services, the child protection services and the Idvas but they should only be working with a very small number, they are not the only option’. Actually what we need to do is say to other agencies ‘what will you do to identify domestic abuse?’ and ‘what do your workers do in response to that?’ So that is going to have a big impact on how we write our next Strategic Plan”
Strategic leader, Site F

Site E published their 2018-2021 Violence Against Women and Girls, Men and Boys strategy after their pilot implementation, and noted their ambition was to ‘get upstream’ in addressing these issues by promoting early help responses and prevention strategies.

Earlier identification of risks and needs for all family members and connected individuals

The One Front Door approach was recognised as having improved professionals’ ability to identify risks and needs by providing a much fuller picture of the situation for each family, resulting in “more informed and safer decisions being made for these cases” (Practitioner, Site E). Several Practitioners reported that it was common for additional risks to be revealed, with Site B collecting data that showed information sharing resulted in an upgraded risk assessment in 17.7% of cases over a five month period.

“Sometimes what seems like a really low level incident that we wouldn’t have acted on in the past, we’ll find out from the [One Front Door] meeting that there’s information that is quite worrying elsewhere, so it seemed like it wouldn’t warrant our intervention at first glance but we do act because of heightened concerns in other areas”
Practitioner, Site B

Other sites provided anecdotal feedback of similar findings and this was also evidenced in our case audits of One Front Door cases. Partner agencies, particularly the DA specialists, were most likely to return a Red Brag rating. However it is important to note that when a contact was assessed as Red by CSC this indicated Section 47 thresholds had been met. This means that professionals had “reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm”²⁰ and requires a slightly different process, as shown in the flow charts above, due to the shorter statutory timescales required for making a decision on such cases. Police were reportedly least likely to Brag cases as Red, suggesting that agencies did not yet have a shared understanding of risk in order to apply Brag ratings consistently.

Case study – Marie

In Site D a notification of DA was received by CSC from police following an assault by Greg on his ex-partner Marie. This incident was assessed to have met the threshold for a Marac referral by responding police officers and was listed at the next Marac meeting in two weeks’ time. The following day the case came through a One Front Door micro-pilot workshop and information was able to be shared in the Brag meeting due to the incident having met the Marac threshold. The CSC representative assessed the case as Green as their information indicated Marie and her three children were living in refuge away from Greg, and CSC were likely to close the contact. Substance Misuse Services (SMS) had been working with Greg for some time and assessed the case as Red. They were aware of a deterioration in Greg’s behaviour, including his alcohol use, following a recent bereavement and they were concerned. SMS stated the police incident indicated Greg was having contact with Marie and their children and based on their knowledge of Greg’s history they assessed that the children may be at imminent risk of harm.

Following the Brag meeting CSC had a much clearer understanding of the risks faced by all family members and a strategy meeting was held later that same day. Information shared in the Brag meeting saved time compared to the old process of completing ‘Mash checks’ as the risks to the children had already been established. As a result services were able to act within 24 hours of the assault taking place. Without the One Front Door process information would not have been shared until Marac, meaning no agency would have the full picture for two weeks.

It is vital that sites have services that can support families before concerns meet CSC thresholds. Two of the three sites who incorporated One Front Door as business as usual gave anecdotal feedback that while they were identifying additional risks, this had not resulted in a significant increase in workload, as the multi-agency discussion would allow the team to identify interventions from any appropriate agency to be put in place to stop concerns escalating prior to meeting the threshold for a social work assessment.

In Site G, all One Front Door cases that did not meet CSC thresholds were reviewed by Early Help (EH) practitioners to look at Early Help Assessments (EHA) through which families could access a range of interventions, from short term work to support families to access universal services, to intensive practical support to meet whole family needs from a family support worker and DA pattern changing courses. In effect this meant that very few contacts were closed with the outcome 'No Further Action'.

In contrast to this, Site F experienced changes in EH leadership which meant One Front Door launched before clear pathways into EH were established, leaving the One Front Door team with a gap in the support available for cases not meeting section 17 or 47 thresholds. A senior social worker within the team reported she felt like everyone was "willing each case to meet social care thresholds". However she was also clear that having CSC involved is a big thing for families and was not always appropriate or necessary and the Site needed options for those families who would benefit from a lighter touch intervention. Although partner agencies were identifying actions they could implement in the majority of cases, the site's data did reflect a significant increase in cases proceeding to a social care assessment. In the first four months of One Front Door implementation 31% of DA contacts from police progressed to a social care assessment, compared to 3% in the same four months the previous year. It is not clear how much of this increase was as a result of having a better picture of the risks and needs within the family, and how much was due to the lack of alternative outcomes as it was not possible to track the outcome of these assessments. The number of contacts which were not closed with 'No Further Action' increased by 25% for the same time periods⁶. A random audit of five cases that were closed with 'No Further Action' revealed missing Brag ratings from relevant agencies. It is important that decisions are consistently made based on the fullest possible picture of what life is like for the family to ensure that risks are not missed.

The identification of a lead professional or agency to co-ordinate actions between involved professionals was also reported to have had a beneficial impact by practitioners. The lead professional was able to collate information, liaise with other agencies and gather a picture of the situation prior to making contact with the family so that actions were completed in a consistent and joined up way which avoided duplication of effort. This was felt to improve the support that could be offered to victims of abuse:

"It's all a lot more joined up, and rather than them hearing different bits of information from different people we can gather everything, find out who is involved, what the background is...then when we come to make contact we already have a picture of the situation and that helps us to build up a relationship, rather than bombarding them with questions"

Practitioner, Site G

Case study – Hayley

A Child Concern notification was received in Site G for Dylan and Calvin after their Mum, Hayley, had called the police following an escalation in threats she was receiving from her ex-partner Leighton over child contact since their separation, leaving her fearful for her safety and that of her sons. The Idva in the One Front Door had worked with Hayley in the past and was aware Hayley was very vulnerable and had expressed fear of the criminal justice system and reporting incidents to the police. In response to this, the Idva ensured that prior to making contact with Hayley she spoke to Police regarding Leighton's arrest and bail conditions, and with the social worker who had supported Hayley to give a police statement. This gave a full picture of the situation so she could answer Hayley's questions and limit duplication of questions. No bail conditions had been put in place, so the Idva quickly made arrangements for a solicitor to attend an appointment with Hayley to look at an injunction to protect her and her children within two days of receiving the referral.

⁶ This refers to cases which were discussed in the One Front Door meeting. Due to changes in external processes in this site the numbers of contacts during the two time periods were very different and as a result comparing the proportion of cases closed with 'No Further Action' would be misleading.

As previously mentioned, Site E received training around engaging with perpetrators and a formal perpetrator programme was offered in the area. The perpetrator programme was externally evaluated, and this report focuses on the role of the intervention as part of a multi-agency whole family approach to safeguarding planning. Follow-up audits completed in Site E over 12 months after the original micro-pilot showed that the perpetrators in two of the six micro-pilot cases had their behaviour challenged by professionals while the children were open to CSC. The two cases below show how One Front Door improves the response to all family members where high risk DA had been identified and Brag rated Red. Rather than solely focusing on the safety of the victim, actions were put in place to meet identified risks and needs for the children and perpetrator in each case. Amanda's case in particular shows how the family had been known to professionals for years, with each holding relevant information about what the children were experiencing, yet this information was not shared and actions were not taken to disrupt the abusive behaviour against Amanda by multiple perpetrators until the One Front Door brought everyone together to look at all members of the family in a joined up way.

Case study – Amanda

Amanda had a long history of contact with CSC relating to DA in several relationships dating back 10 years, most of which are closed with 'No Further Action'. Amanda's daughters Keira and Scarlett had been on several Child in Need (CiN) plans from 2014 to 2016 though these largely seem to be related to concerns around Amanda's alcohol use. By 2016 Amanda is in a new relationship with Harvey who is also abusive to her. Later in 2016 an ICPC is held for Keira and Scarlett (age 9 and 7) but they remained on a CiN plan, despite disclosing to professionals that they had witnessed multiple violent incidents between Harvey and Amanda. Almost as soon as that CiN plan ends in May 2017, a further serious incident occurs and the girls are placed back on a CiN plan which is closed on 3 Nov 2017, after Amanda reports her relationship with Harvey has ended.

Just two days after the end of the CiN plan Harvey perpetrated a serious physical assault on Amanda. The resulting referral to CSC went through the One Front Door micro-pilot and was Brag rated Red by Police. Information sharing shows that Education had concerns as a result of Scarlett's disclosures about Harvey coming to their house, the children's health records show extensive safeguarding notes in relation to DA but no previous health referrals. Probation share that Harvey has been on license throughout his relationship with Amanda but no action had been taken to recall him despite numerous police incidents and Probation being aware Harvey had been abusive to previous partners as the license restrictions did not relate to him having contact with Amanda. Other information shared indicates both adults have substance misuse and mental health issues for which they are not receiving support.

Following the One Front Door information sharing Scarlett and Keira were placed on a CP plan which was still in place over a year later when the follow up visit was completed. Case notes indicate that legal conditions were put in place to prevent Harvey having contact with Amanda or the children and Probation had delivered 1-1 work with Harvey to look at the impact of his behaviour on relationships and children. Amanda had engaged with support from an Idva and Scarlett and Keira were receiving direct support around their experiences of living with DA.

Case study – Feriha

Feriha's four children had been referred to CSC four times prior to the One Front Door micro-pilot. On two occasions these referrals relate to the older children, Defne and Adnan, disclosing to school staff physical punishments they have received for misbehaving. The third follows Adnan contacting police and stating he had been assaulted by his Father, Hazim. Although referrals meet Section 47 thresholds twice and a third referral also results in a CSC assessment the children are only placed on a plan (CiN) following one of these referrals. There is little documented regarding contact with Hazim, and no record of his arrest regarding the alleged assault on his then 12 year old son. The focus is on Feriha and her parenting skills.

In December 2017, Adnan calls Police reporting Hazim has assaulted Feriha in front of all four of the children, and on attending the family home Police document she was seen to have swelling, bruising and a cut visible below her eye, it later transpires she has a fractured cheekbone. Feriha tells Police Hazim had threatened to beat the children and when she had stepped in to prevent this he had assaulted her instead, while she was holding their 8 week old son. Police Brag this case as Red and document that a Dash Ric completed with Feriha, scoring 14 ticks which is indicative that she was at high risk of serious harm. DA specialists also Brag the case as Red, given Feriha's disclosure of previous serious incidents. School share information relating to concerns about Adnan's aggressive behaviour. The family GP shares details of Feriha having a previous cheek fracture as a result of DA. A CSC assessment is recommended which results in the children being placed on a CiN plan which remains open until March 2019. Hazim is prosecuted, leaves the family home and attends a perpetrator programme as part of his community order. Feriha engages with an Idva and the children are also provided with support in relation to their experiences of DA. After Hazim completes the perpetrator programme he is assessed by social care and the family reunites.

When One Front Door cases meet Section 47 thresholds, decisions on social care actions are required within 24 hours. This risks excluding information from some agencies who are not able to contribute information within that timeframe. Even where a high level of risk to the child has already been identified it is important that processes for requesting and collating information are streamlined to facilitate all representatives sharing relevant information and concerns for all family members in order to form a whole picture of risks and needs for the family. Actions to support adults within the family should still be considered as part of providing the best support to children and their families.

Other sites did not demonstrate the same improvement with regard to challenging the behaviour of the perpetrator. Site F has no formal perpetrator programme and Probation only contribute to the One Front Door meetings where an individual is currently open to them and at least one agency had Brag rated a family member Red. In cases where they are present, benefits have been observed. Probation have taken away actions such as following up on breached conditions (previously not acted on), and leading on supporting the perpetrator to access support for their own needs such as substance misuse. In one instance Probation reflected that the discussion around that family had changed the way they viewed the perpetrator of abuse, as they had failed to recognise the degree of risk he posed to partners and children previously. The allocated offender manager was informed to enable the new information to inform future work with the perpetrator.

Although staff in Site G reported that they were including perpetrators in discussions around the family needs much more than before, their local perpetrator programme had been going through recommissioning in the early days of their pilot, and no new referrals were being accepted. Information and input from Probation was limited as they were only present one day per week. None of the cases audited included actions to address the wider support needs of perpetrators. Much like with other needs, addressing the perpetrator's behaviour at the earliest opportunity gives the best likelihood of achieving change. The DA JTAI re-iterated the need for early intervention, stating "the pattern of domestic abuse is that it starts small. The level of intervention needed to halt it becoming more serious is much less challenging for the perpetrator to engage with and much less costly for the public purse"²¹.

Paul D'Inverno, Child Protection Specialist Advisor, re-iterated Ofsted's support for a whole family approach when working with families experiencing DA, stating "*it's important to use a family-centred approach, which means addressing all needs and risks within individuals in a family holistically*"²². During their DA focused inspection programme in 2016 Ofsted "*found a pattern where professionals focused on the victim. In all the cases we saw, this was the child's mother, but we know domestic abuse can happen in any relationship. In the best case scenarios, this represented an understandable focus on the mother as a victim of crime and in need of protection. But, even in the best cases, there was often a lack of accountability or responsibility attributed to the perpetrator of the abuse. Furthermore, in a minority of cases, there was an inappropriate attribution of responsibility on the mother to protect her children*"²³. Ofsted expect that direct work with children to address the emotional and mental impact of living in homes where there is DA should be available in every local authority.

Conclusions

The evidence above demonstrates the progress by the Pilot sites towards implementing a One Front Door within the three year funding period. Four of the seven pilot sites reached the implementation stage of the project, with three of these four sites embracing a One Front Door approach to multi-agency working as business as usual. Practitioners in these sites are overwhelmingly positive in their opinions of how this new way of working contributes to effective identification of risks and needs and improving their response to the whole family where DA is an identified issue.

“It is effective and it really does work”
Service Lead, One Front Door Pilot Site

Multi-agency working has become more effective by becoming more collaborative. This was evident even in the two implementation sites who had a Mash before they were selected as One Front Door sites, demonstrating that co-location alone is not sufficient for effective collaboration. An approach that brings statutory and third sector organisations together on an equal footing, with a shared ownership of the processes and outcomes is required, in order to effect culture change. Practitioners within One Front Door should be given opportunities to undertake shared training, share their expertise and build a team identity. As stated in the updated Working Together to Safeguard Children guidance, *“no single practitioner can have a full picture of a child’s needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action”*²⁴.

The Brag process is key to ensuring that the invaluable expertise of all agencies is considered when risk assessing all individuals within the family, along with connected individuals. The process requires analysis of the information held by each agency based on agency-specific expertise, moving away from information sharing as an administrative action to one that will contribute to professionals having a full picture of what life is like for the children and adults within each family. Assigning a Brag to each family member demonstrates that their risks and needs have been considered, and creates a shared language for professionals from diverse specialisms to talk about and understand risk.

The sharing of information, and processes to assess whole family risks and needs are necessary to inform a proactive holistic action plan. One Front Door action plans should be pro-active and identify opportunities to prevent needs escalating by providing support at the earliest opportunity. Agreed actions should be co-ordinated by a lead professional to ensure they are implemented. This will also help to avoid confusion and repetition for family members and reduce duplication of effort by professionals. SafeLives echo the JTAI recommendations that the focus of intervention should not be limited to a crisis response to children and adults at immediate risk of harm. Direct support designed to “repair long term damage to child victims”²⁵ from DA and other ACEs should be available before statutory thresholds are met, along with strategies which aim to prevent future harm and interventions to change the behaviour of perpetrators.

“The best long-term outcome for any child is that the abusive parent changes their behaviour”²⁶

Local authorities must shift their focus away from scrutinising the actions of the victim of abuse and instead place responsibility with the perpetrator. Where required, training should be provided to support professionals to understand and feel confident to challenge the behaviour of perpetrators of abuse and provide support to understand the impact of this behaviour on children. Addressing the support needs of perpetrators can present an opportunity to engage them in social care processes and nudge behaviour change.

In addition to positive feedback from practitioners and strategic leads within each site, there has been outside scrutiny of the approach. Ofsted have inspected all three of the sites where One Front Door is business as usual, and their reports have made particular mention of how this approach has improved the multi-agency response to families experiencing DA. One site received an Outstanding rating, with their report from Ofsted highlighting the One Front Door meeting:

“The daily meeting provides an additional layer of scrutiny regarding decision-making and ensures that all actions are responsive and proportionate to risk. Management decision-making is effective, timely and child-centred, with a clear rationale that identifies next steps and a seamless transfer into family well-being or assessment services”²⁷

In another area, One Front Door itself was praised; however Ofsted expressed concern regarding delays in receipt of DA notifications from Police:

“Within the ‘one front door’, agencies work well together and provide an effective, coordinated response to children and families where domestic abuse is a feature. Police notifications to this service are not consistently timely, leading to unnecessary delays in children being seen, and the assessment of risk and provision of services by agencies”²⁸

The evidence from this pilot indicates that implementing the first stage of the One Front Door has enabled the pilot sites to make good progress towards meeting the objectives of:

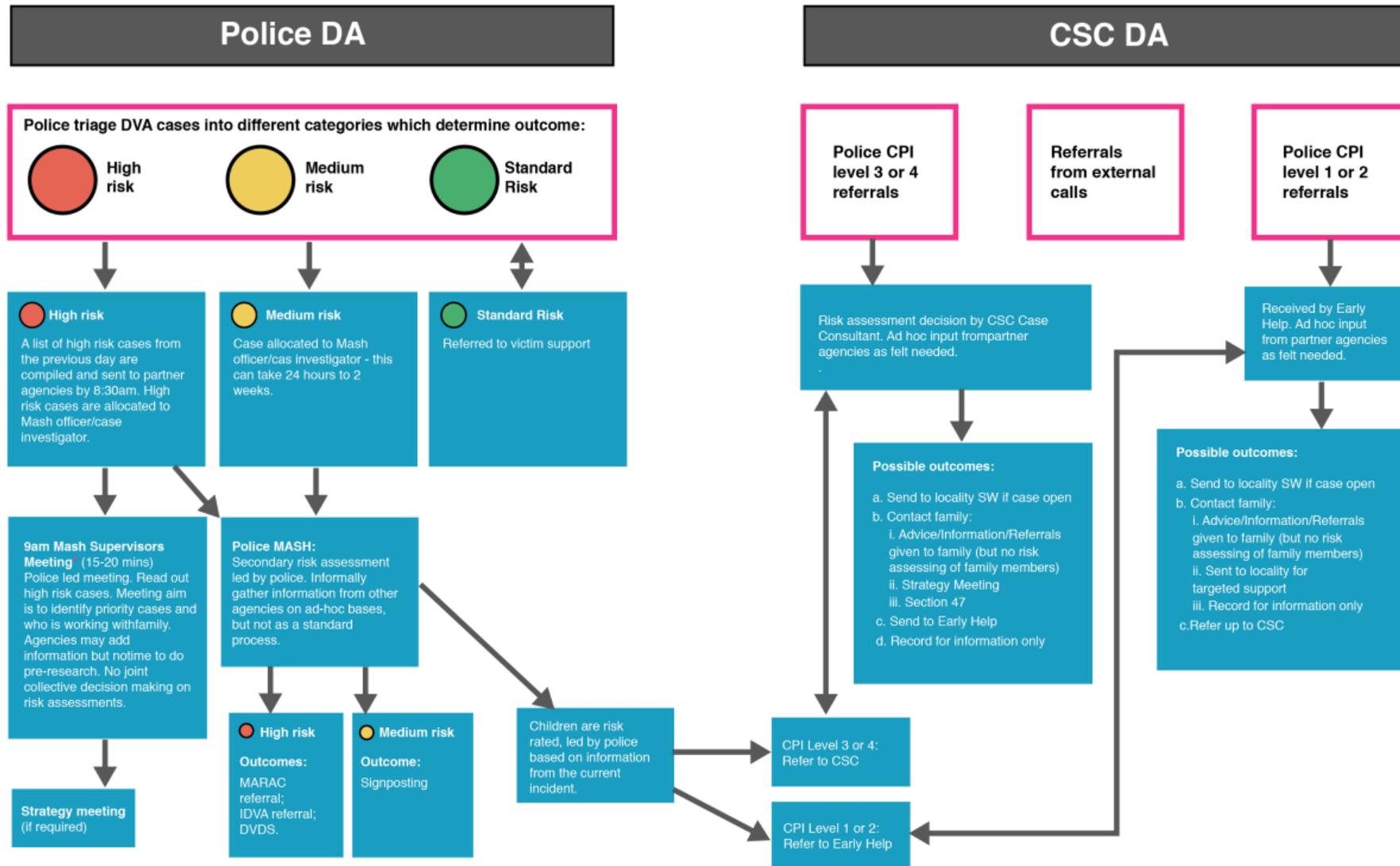
- An integrated pathway for all voluntary and statutory agencies to refer child safeguarding concerns and/or any young person and/or adult experiencing, or perpetrating DA
- A specialist team of multi-agency professionals who work collaboratively and simultaneously to assess and manage risk and need of all individuals and the whole family
- A cumulative approach to identify and share information on all relevant individuals (at risk or posing a risk) at the earliest opportunity
- A pre-emptive, co-ordinated response and plans for all vulnerable children and victims and perpetrators of DA, both individually and as a family; so that next steps are clear, timely and accord with shared responsibilities to protect children and vulnerable adults

Our next steps are to stress test this approach in additional sites and continue to build the evidence base supporting One Front Door as an effective whole family response. Future work in current pilot sites will aim to align all multi-agency responses to the principles of One Front Door. By maximising resources and avoiding duplication of effort the needs of the whole family will remain central to our work.

Another aim of future work will be to improve the response to families experiencing DA who are known to have low rates of police reporting, such as those from BME or LGBT+ communities and male victims. Collecting more detailed demographic data during future work will aid our understanding of how One Front Door can improve the response to families within other groups that services do not engage well.

Appendix A

The flow chart below illustrates the complex referral pathways and single agency decision making points in the Site C Mash.



***Agencies in the 9am meeting:**
Regular attendees: Police (chair), CSC, ASC, Missing Persons, EDT, Idva, Op Encompass, Probation

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