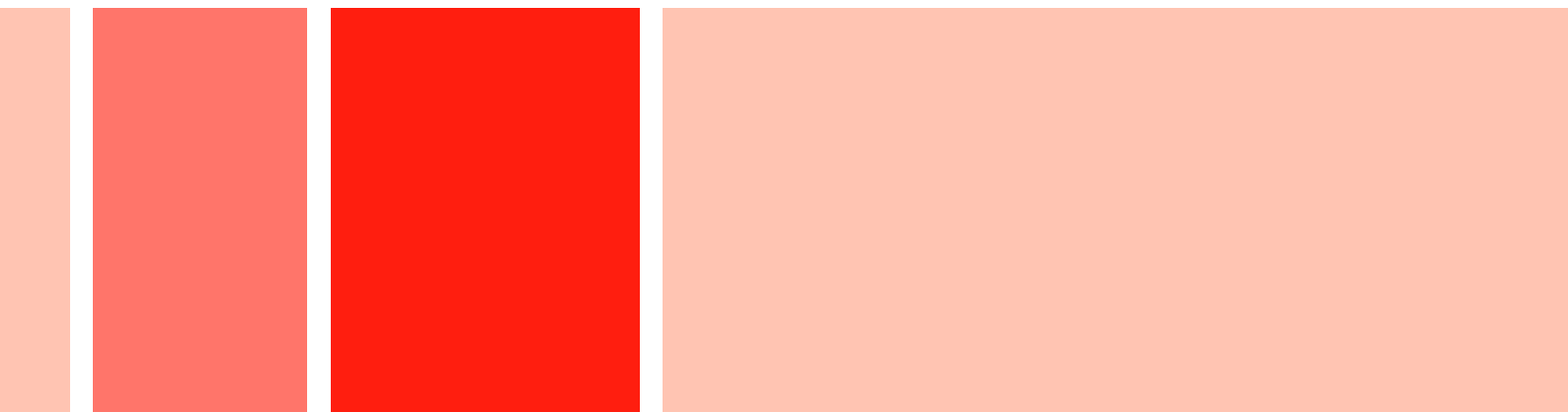www.cymru.gov.uk

Gwent Missing Children Hub

Formative evaluation: Summary of Findings and Recommendations

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Glossary

Acronym	Definition
CSE	Child Sexual Exploitation.
MIRAF	Missing Individual Risk Assessment Form Guide.

1. Research aims and objectives

1.1 Cordis Bright have been commissioned by the Welsh Government to conduct an evaluation of the Gwent Multi-Agency Missing Children Hub ("Hub") project. The evaluation is taking place over three phases: inception, formative and summative. This is the formative report.

1.2 The aims and objectives of this formative report, as set out in the Welsh Government evaluation specification, are to:

- examine the implementation of the project, to assess whether the Project is operating as intended;
- address the extent to which the Project contributes to the intended outcomes and how; and
- draw lessons learnt for the Project and/or for future/wider roll-out.

2.   Methodology

2.1   At the inception phase of this evaluation we developed a logic model which set out the theory of change behind the Hub, including its inputs, activities, outputs and intended impacts and outcomes. This was developed through: a document review, a best practice literature review and consultation with the Hub. At this formative phase of the evaluation we have developed a mixed methods approach to test the extent to which the theory of change is working in practice.

2.2   The mixed methods used at this formative stage included: a review of documentation and desktop data such as the terms of reference and the Gwent Protocol, eight face-to-face interviews with Hub staff; 16 interviews with stakeholders such as social workers, education staff and police officers; eight consultation case studies which can be seen in Appendix 1 (including multi-agency focus groups and face-to-face interviews with young people who have been missing and their parents/carers); and outcomes focussed case studies.[1]

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[1] Outcomes focused case studies are an innovative evaluation method designed by Cordis Bright which capture context, interventions, and progress made against intended outcomes.

3. Key findings

Objectives and rationale of the Hub

Aims and objectives

3.1 Both the document review and interviews with Hub staff and stakeholders showed the following aims and objectives underpinning the work of the Hub:

- to improve the lives and outcomes of children who go missing
- to reduce the number of missing children episodes
- to reduce repeat episodes of missing or absent children
- to prevent children from going missing
- to reduce the likelihood of children going missing experiencing or perpetrating crime
- to reduce unnecessary demand on other services and ensure cost-effective working
- to increase reporting of missing children
- to develop ideas for more efficient ways of working
- to continuously improve services to Gwent citizens
- to improve multi-agency working and information sharing
- to test the multi-agency risk assessment and information sharing model.

3.2 Interviews with staff and stakeholders suggested that the Hub is primarily focused on improving outcomes for children. This is in line with the Hub's proposed theory of change and logic model developed during the inception phase of the evaluation, which can be seen in Appendix 2.

3.3 The majority of Hub staff and stakeholders agreed that the aims and objectives of the Hub are appropriate and showed high levels of 'buy-in' in relation to these, suggesting that professional stakeholders are being effectively engaged in the work of the Hub.

Rationale behind the Hub

3.4 Documentation reviewed showed that the Hub was established to resolve clearly defined problems which had been identified in relation to services working with children who go missing, such as inadequate

communication between agencies and a lack of understanding about why children run away.

3.5 Staff and stakeholders described the rationale of the Hub in a similar way to that outlined in the documentation reviewed. They reported that the Hub is designed to fill a gap in services working with children who go missing, particularly regarding making information related to missing children accessible with the aim of improving practice among stakeholders to help improve outcomes for children who go, or who are at risk of going missing. This shows that the rationale behind the implementation of the Hub is understood by Hub stakeholders consulted as part of this evaluation.

The work of the Hub

3.6 The key processes and activities of the Hub are: identifying cases of missing or absent children who have been reported to the police; gathering information about the child through multi-agency databases and / or consultation with other professionals, parents or carers; conducting or updating a Missing Individual Risk Assessment Form (MIRAF) on every child that is report missing; agreeing a shared action and response plan; sharing this information and delivering debrief interviews and mediation, where appropriate.

3.7 Completion of the MIRAF and delivery of debriefs were Hub activities most commonly identified by staff and stakeholders in interviews. The MIRAF approach was seen as a key achievement of the Hub, particularly in terms of facilitating information sharing and multi-agency working. Debrief meetings were viewed positively as they were seen to: ensure children are listened to and have a voice; encourage children to disclose important information; and be useful for gathering intelligence.

3.8 The completion of the MIRAF includes: gathering of relevant information from professionals, databases and parents/carers assessing risk (including overall risk, likelihood of going missing and

consequences of being missing) sharing information, joint risk assessment and plans through an online portal.

3.9 A minority of stakeholders suggested that the MIRAF could be kept more up-to-date. Hub documentation states that the MIRAF is updated after a child has gone missing five times or more in one month.[2] It may be helpful for Hub staff (and potentially stakeholders) to have access to a documented protocol regarding when and how the MIRAF should be updated in order to ensure consistent practice among Hub staff.

3.10 The MIRAF analysis showed that category definitions could be made clearer. It may be helpful for Hub staff (and potentially stakeholders) to have access to documented protocol regarding risk category definitions to ensure consistent risk assessments are completed.

3.11 The delivery of debrief interviews is also a key part of the Hub's work. They are intended to:

- provide the child with someone to listen to them

- provide the child with information, advice, guidance and advocacy in general

- gather information and intelligence to feedback into the MIRAF

- ascertain reasons for the child's missing episode

3.12 Hub documentation states that the Hub team considers all children who have been reported missing or absent for the debrief service.[3] It states that eligibility is determined by 'researching systems and filtering those where there are identified concerns, risks or where there is potential for harm'. The Hub informed Cordis Bright that it aims to provide children who have gone missing with at least one debrief and that the Hub will determine future debriefs according to risk levels. It was not always clear how this process was working in practice. It may help to ensure consistent and transparent practice if the Hub produces

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[2] Briefing report Board Dec
[3] Briefing report Board Dec

protocols and written guidance on debrief allocation and decision-making.

3.13   One of the key innovative aspects of the approach taken by the Hub is that it takes a different approach to missing children from that advocated in the All Wales Protocol for Missing Children (2011), particularly in its definition and use of the terms 'missing' and 'absent' and its provision for multi-agency working. The innovative Gwent Protocol is designed to 'eliminate waste in the process, reduce risk to children and young people and create greater consistency in approach across agencies.'

3.14   The Hub promotes the use of the MIRAF and adherence to the Gwent Protocol amongst professionals by providing training to a range of professionals working with children who go missing which covers: Gwent Protocol to working with missing children; appropriate reporting practice; use of the MIRAF; and use of multi-agency information. The Hub also delivers tailored training packages for a range of agencies and professionals.

3.15   Staff and stakeholders mentioned that the Hub delivers Child Sexual Exploitation (CSE) related services to young people, grief counselling and contribution to the care planning process, which are also not documented in the 'key processes' of the Hub.

3.16   Staff reported at the time of interview that the Hub had not yet started to facilitate service user involvement, to deliver workshops for young people and parents/carers, or to contribute to schools' education programmes. However, documentation shows that planning had begun for a 'Peer Education' programme in December 2014 (see section 8.3.2 of the full report). This suggests that the role of the Hub as a source of primary prevention is an area which has recently begun to be developed and which could develop further in the future.

3.17   These key processes and activities are clearly designed to address the issues facing services working with children who go missing which were identified prior to the inception of the Hub, as explored in section

5.3 of the full report, such as those related to multi-agency working, information sharing and availability, early identification, and direct work with children to understand why they go missing. The literature review conducted as part of the inception report highlighted similar service factors which are important in improving outcomes for missing children, such as accurate data and information, effective debrief meetings and multi-agency working. Therefore, assuming that these issues really were or are hindering services' ability to improve outcomes for missing children, the Hub's work appears to be appropriately designed to achieve its aims and objectives.

Monitoring and performance management

3.18   The Hub monitors its performance through, principally, the Llamau debrief and mediation quarterly reports and update reports for the Project Board. These provide increasingly effective approaches to monitoring and performance management which could still be developed and improved further. In particular, as part of a strategic planning process, the Hub should ensure that monitoring and performance management processes and tools are developed within a SMART[4] framework.

3.19   The Llamau quarterly reports provide an overview of the work being done by the Llamau debrief and mediation service and help to give a sense of what this service is achieving in terms of outputs and, in some instances, impact and outcomes. As an enhancement, the reports could analyse the number of debrief sessions provided per child to give a greater sense of the distribution of the debrief service across service users.

3.20   The Hub has made good progress in developing its approach to monitoring and performance management over time through its update reports for the Project Board. Highlight reports were produced by the Hub for the Project Board until 2014 and provided a 'project overview', 'activities completed since last report', 'activities planned

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[4] Specific, Measurable, Achievable, Relevant, Timebound

before next report', 'benefits realisation', 'project status' and 'risks and issues'. One report also provided 'good news stories'. The format and content of these reports improved significantly in January 2015 to report against specified themes and provide evidence related to Hub outcomes, such as case studies on progress and outcomes for the ten most frequently missing children. These case studies help to give a sense of the complexity and chronology of the cases of the children who most frequently go missing.

3.21   The new Project Board update reports also mean that the Hub has begun to deliver the expected output of producing reports which identify trends and key issues in relation to missing children.

3.22   Both the Llamau quarterly reports and the update reports for Board Members could demonstrate the work and impact of the Hub more effectively if they:

- collect and analyse data consistently across time

- provide methodological information alongside monitoring data[5]

- analyse the data in relation to intended outcomes, such as analysing missing children numbers in terms of those who are subject to a child protection plan or collecting feedback from debrief service users which relate to what the service is trying to achieve

- report and compare monitoring data against SMART targets to gauge and demonstrate progress and achievements.

3.23   The case studies documented in the Project Board update reports should include information about the Hub's involvement in these cases, to better understand if and how the Hub is making a difference to these children's lives, i.e. what happened because of the Hub, and conversely what would have happened if the Hub had not been involved?

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[5] For example, ensuring that the following are documented: (a) how the data was collected, (b) when the data was collected, (c) who the data was collected from and by, and (d) how the data was analysed.

3.24   There is evidence of monitoring data being used to shape future activities. For example, the March 2013 - April 2014 Llamau report presented a breakdown, by local authority, of the number of referrals made to the mediation service. This report noted that the lack of referrals made by one of the local authority areas needed to be addressed and described how actions would be taken to promote the service in that area. If the recommendations outlined above are implemented, the Hub will likely find it easier to use monitoring data to shape future activities.

3.25   A minority of stakeholders reported that the monitoring and performance processes and tools used by the Hub could be improved further. For example, it was suggested that internal performance management within the Hub team itself could be developed and that a 'more scientific' approach could be taken to the analysis of data related to MIRAF use.

Success of implementation

Inputs and resources

3.26   The Hub consists of 13 staff (11 full-time equivalent (FTE) and 2 part-time equivalent (PTE)). It includes members of staff from the police, social services, health, Llamau, education and Barnardo's/SERAF. Hub staff reported that the Hub would benefit from dedicated resource for administration, as is evidenced in section 8.5.3 of the full report.

Volume of activities and outputs

3.27   If the Hub develops targets for all of its key outputs in the future (for example, numbers of training sessions delivered, number of debriefs) it will be possible to assess the extent to which the Hub's outputs have been delivered to the expected volume. At present, other than completing MIRAFs for all missing or absent children, there are no other specific targets set in relation to Hub outputs, such as number of debriefs to be delivered or training sessions delivered, so it is not possible to assess whether the Hub is delivering outputs in line with

expectations. However, documentation shows that outputs have been delivered to the levels outlined below.

MIRAF

3.28   In its first six months of operation the Hub exceeded expectations established in its Business Case relating to the number of MIRAFs it aimed to complete.

3.29   In July 2014, the Hub reported that it had completed 728 MIRAFs since April 2014. In order to demonstrate that the MIRAF is completed for all missing children, the Hub should compare the number of MIRAFs completed with the number of children who went missing during the same period or, as it did in its first six months, in comparison with targets. This will allow the Hub to demonstrate the proportion of missing children for whom a MIRAF has been completed and thus to provide a sense of the level of Hub outputs compared to expectations.

Debrief service

3.30   It is not documented why the average number of debriefs per month varied from, for example, 52 per month in July – October 2014 to 21 per month in October – December 2014, as shown in Table 1.

Table 1: Summary of debriefs per month

Report	Number of months	Total debriefs	Average debriefs per month
March 2013 – April 2014[6]	14	480	32
April 2014 – June 2014	3	119	40
July 2014 – October 2014	4	206	52
October 2014 – December 2014	3	62	21
January 2015 – March 2015	3	98	33

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[6] We have used the dates which are stated on the Llamau reports. Although there appears to be some overlap in dates in that April 2014 is, for instance, seemingly accounted for in two reports, the extent of this overlap in terms of data is not known.

3.31   Our calculations suggest that in October – December 2014, 21% of children who had been missing (or absent) received a debrief interview in the same period. It would be helpful for the Llamau quarterly reports to regularly monitor the proportion of unique missing (or absent) children who receive a debrief, as this helps to place the level of provision in the context of the intended target audience of the Hub, i.e. all missing or absent children in Gwent or in comparison with SMART targets. This will help to give a sense of level of outputs in comparison with expectations.

3.32   The proportion of debrief interviews which have been delivered as repeats, i.e. delivered to a child who has already had one or more debriefs, has also varied over time. In the first year of operation 19% of the debriefs which the Hub delivered were repeats in comparison with over 33% or more which were repeat referrals from April 2014 onwards. Given that there is evidence that the debrief service was stretched in its first year of operation (see section 8.4.1 of the full report), it is possible that the Hub focused on ensuring that as many children who had been missing as possible accessed at least one debrief initially, rather than delivering repeat debriefs. Documented protocols would make the Hub's rationale of allocating debriefs more transparent.

3.33   Based on our calculations between 17% and 30% of children supported by a debrief worker were referred onto other agencies for additional support from July 2014 – March 2015. However, this information does not indicate if these services were 'appropriate' given the needs of children who were referred. This is something which the Hub could assess through developing service user and stakeholder feedback mechanisms.

3.34   The Hub is contributing to care planning. Between March 2013 and March 2015, Hub staff attended a total of 174 external meetings. They were most likely to have attended strategic meetings (78 attendances overall), looked after children reviews (23 attendances overall) and care planning meetings (23 attendances overall). It would help to

provide a sense of level of success if the Hub reports these alongside the number of meetings it has been invited to and/or its own targets in this area.

Mediation

3.35   From March 2013 to March 2015, 52 children and young people have been referred to the mediation service. Some of these children had more than one mediation session. In the future, Llamau should continue to monitor and report the absolute number of mediation interviews which were delivered in each quarter in order to allow for comparison across time periods. In addition, if these numbers are reported in comparison to SMART targets, it will help the Hub to gauge progress in terms of the extent to which it is delivering the expected volume of (unique and/or repeat) mediation interviews.

Take-up of activities and outputs

Stakeholders

3.36   The Hub's activities are being taken up by large numbers of stakeholders who work with children who go missing. For example, it is estimated[7] that the Hub has delivered training to around 1,250 professionals from a wide range of agencies since its inception, all of whom were informed about the Gwent Protocol. In the future, the Hub should collect more exact figures on the following:

- number of staff from all agencies who attended training
- number of residential units and hostel staff who attended training
- number of foster carers/ parents and carers who attended training.

3.37   The Hub reports that there were 600,000 hits on MIRAF web pages between November 2013 and November 2014, and a further 184,000 hits in the fourth quarter of 2014/15.[8] It has been stated that 'usage of

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[7] As the Hub has not collected precise numbers of training attendees, it is assumed the number of participants for each course delivered by the Hub is 30 based on the Hub's best estimate.
[8] Board Meeting 13 April 2015 performance reports, p. 2.

the MIRAF is increasing'.[9] This suggests that the Hub is achieving increasingly high usage of the MIRAF amongst professionals.

3.38   The majority of stakeholders interviewed reported that they are aware of, and have used, the MIRAF. However, one staff member suggested that education and social services could make more use of the MIRAF and another stakeholder reported that the police could sometimes be more thorough in checking the MIRAF before responding to missing children cases.

3.39   Three of the eight consultation case studies suggested that there could be greater use of the MIRAF amongst some professionals. Consultation case studies overall suggested that more awareness of the MIRAF amongst some professionals would help to increase take-up and usage. This issue links to the Hub's ability to ensure that partners are aware of and use MIRAF. The Hub is reliant on partners being aware of its practice and of using MIRAF effectively.

3.40   Consultation case studies suggested that general awareness of the Hub and its role amongst some professionals could be enhanced further. As the Hub is able to deliver training to an increasing number of professionals, it is expected that this will help to raise awareness. This will help increase the Hub's sphere of influence in terms of achieving intended outcomes that are reliant on the effective practice of partner agencies.

Children, young people and parents/carers

3.41   The Hub has been able to effectively engage a very large proportion of children it refers to debriefs. For example, between July 2014 – March 2015, over 90% of children referred to the debrief service took up the opportunity and engaged. However, the Hub may also choose to analyse the proportion of children who received a debrief compared with all children in Gwent who have gone missing, as this is ultimately the target audience of the service. The Hub should also record reasons for not referring children to a debrief. Such an analysis will

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[9] Gwent Missing Children Board report - Jan 15, p. 10.

help to provide the Hub with a sense of the degree to which it is achieving take-up amongst its key target audience and to assess its provision accordingly.

3.42   The Hub is yet to engage children **who are at risk** of going missing for the first time through peer mentoring, workshops or contributing to schools' education programmes. However, the Hub has begun to make provision with regards to the former and would benefit from making provision for workshops and schools work, in order to engage this target audience. Staff highlighted this as an area of future development for the Hub.

Quality of activities and outputs

3.43   If the Hub establishes SMART targets in relation to the quality of activities and outputs that it seeks to deliver, it will be possible to establish how successful it has been in this area. Nevertheless, documentation, interviews with staff and stakeholders, and consultation case studies, show that overall the activities and outputs of the Hub have generally been delivered to the standard expected by staff, stakeholders, children and young people.

MIRAF

3.44   The majority of both staff and stakeholders reported that the MIRAF has been a very successful element of the Hub's work and that it had been delivered to the level of quality that they would expect. Reasons given to explain why the MIRAF is perceived as high quality and successfully implemented include: the information presented is consistent and in-depth; it makes information more accessible; information on the MIRAF can help to strengthen a case for intervention, and decision-making has become faster and more informed.

3.45   A minority of stakeholders suggested that in some cases the MIRAF could be improved further by ensuring that all records are kept more up-to-date and that technical issues are resolved, such as automatic logging out, slow processing and providing time-stamped information.

However, issues such as automatic logging out are necessary to ensure MIRAF data is stored and accessed securely.

3.46   Analysis of ten MIRAF risk assessment records (see section 9.3.2 of the full report) also showed that there is scope for the Hub to further improve the quality of the MIRAF ensuring that reasons for risk judgements are provided in the 'response' or 'rationale' sections of the MIRAF risk matrix. This could also provide useful contextual information for other practitioners to understand why risks have changed and how the Hub may have been involved, as well as helping to demonstrate transparent decision-making.

Debrief service

3.47   The debrief service was also consistently mentioned by a majority of both staff and stakeholders as a very successful element of the Hub's work and was perceived by children and young people to have been delivered to a high quality. It was felt that it is effective because the debrief workers are independent and approach children and young people differently to statutory agencies. This was seen to help facilitate engagement of children with the service.

3.48   Reasons given to explain why the debriefs were perceived to be delivered to a high quality by staff and stakeholders were that: they are delivered in a timely fashion; debrief workers make children feel comfortable; debriefs enable higher rates of disclosure; allow for more accurate and up-to-date information and intelligence gathering, including reasons for going missing; and facilitate appropriate responses to be put in place.

3.49   Consultation case studies and outcomes focused case studies also confirmed that debriefs were delivered in a timely and considerate fashion, suggesting that they are delivered to a high quality. Children, professionals and parents/carers who participated in the consultation case studies also reflected positively on the debrief (and in one case, mediation) service, typically describing it as 'helpful'.

Training

3.50   Most stakeholders were aware that the Hub delivers training and most reflected on it positively, suggesting that it has been delivered to a sufficient level of quality.

3.51   A minority of stakeholders suggested that refresher training would be helpful to ensure that new staff are trained and that existing staff are reminded of the Gwent Protocol.

3.52   The Hub should develop monitoring and service user feedback tools which should be completed by all training attendees. These tools should measure how far intended impacts have been achieved with stakeholders through training, such as improvements in knowledge and understanding of issues connected to missing children. As well as demonstrating impact, it will also help the Hub to identify any areas of improvement.

Improving multi-agency working

3.53   Interviews with staff and stakeholders suggested that the Hub is helping to improve multi-agency working and reduce duplication among professionals working with children who go missing. For example, stakeholders reported that professionals are better able to share and have access to relevant information and that service users are less likely to have to repeat themselves to different professionals now. Staff and stakeholders reported that the multi-agency model within the Hub itself has helped to foster multi-agency working more broadly because of the Hub team's varied connections, knowledge and understanding.

3.54   One staff member suggested that while the Hub has effectively worked with agencies such as the police, social services, and SERAF, more could be done to work together with housing agencies.

3.55   Four of the eight consultation case studies (which can be seen in Appendix 1) provided evidence that professionals worked well together (case studies: one, four, five and seven) and four case studies (case studies: two, six, seven and eight) provided evidence

that professionals shared information effectively to support the young person. However, it was not always clear that this multi-agency working resulted from the intervention of the Hub.

3.56   In three of the consultation case studies, there is evidence that there could have been greater multi-agency working around the young person, particularly with regards to professionals' partnership working with the Hub. In three of the consultation case studies there is evidence that professionals could have been better at sharing information to support the young people, could have made greater use of the MIRAF (for examples, see section 8.5.2 of the full report) and, in one case, that duplication could have been avoided further. It was suggested by participants that greater awareness and understanding of the Hub would help to facilitate this.

3.57   One consultation case study suggested that the Hub has helped to improve multi-agency working by ensuring that professionals have a consistent understanding of the Gwent Protocol. However, two of the consultation case studies suggested that some professionals and carers still need a better understanding of the Gwent Protocol and, in particular, the difference between 'missing' and 'absent' categories.

Improvement areas

3.58   Other areas for improvement which were identified by staff and stakeholders included: increased staffing resources, especially administrative; developing the Hub's direct work with children and families; extending the remit of the Hub to include adults; developing strategic leadership; and provision of a 24 hour service.

Success at improving impact and outcomes

Impact on stakeholders working with children

3.59 Documentation, interviews with staff and stakeholders, and outcomes focused case studies, as well as a minority of consultation case studies, provide evidence that the Hub has had a positive impact on professionals working with children who go missing in a number of ways, such as improving professionals':

- knowledge and understanding of issues connected to missing children
- access to accurate information in relation to children who go missing
- understanding of risk in relation to particular children
- ability to work together
- ability to work more efficiently.

3.60 Interviews with staff and stakeholders suggested that the Hub has helped professionals to respond appropriately to missing children and has improved professionals' attitudes to missing children. In particular, it has helped raise awareness of the seriousness of children going missing.

3.61 However, one interview with a stakeholder and several of the consultation case studies showed that the understanding of 'missing' and 'absent' categories amongst some professionals and carers could be improved further. The consultation case studies also indicated that some professionals could be better informed in relation to specific cases of missing children. Raising awareness and increasing use of the MIRAF would likely achieve this.

3.62 In the future, the Hub can more convincingly demonstrate its impact on professionals through its own monitoring and performance management processes by ensuring that it takes a more systematic approach to collecting feedback from stakeholders which captures information about, for example, (a) the background characteristics of the stakeholder, (b) why they were in contact with the Hub, (c) how

the Hub helped, (d) how satisfied they were with the Hub, and (e) how the Hub could improve in the future.

Reducing the number of children who go missing repeatedly

3.63 There is promising evidence which suggests that the Hub may be reducing the number of children who go missing repeatedly (this is shown in 3.64). However, a more robust approach to monitoring and performance management, in line with the recommendations made in this report, is necessary in order for the Hub to be able to demonstrate this robustly.

3.64 Hub documentation states that since the Hub's inception 'the frequency of missing episodes amongst the top ten in the cohort has reduced by approximately 50%'.[10] Hub staff explained that this was calculated using COMPACT[11] data although the data was not presented alongside this conclusion.

3.65 One Hub document reviewed presented data relating to the frequency of missing among the 'top ten' missing children.[12] It shows that in 2013, the year of the Hub's inception, the average number of missing episodes among the 'top ten' was 39 times compared with 42 times in 2012. This shows that the frequency of missing episodes reduced by 7% among this cohort after the Hub's inception. Although it is not known the extent to which this decrease took place among the same children across years or the extent to which this was due to the Hub. It should also be noted that this reduction was found for just the top ten children and the reduction should be treated with caution in attributing success to the Hub. Through following recommendations made in this report the Hub should be able to collect and analyse data in a more systematic way to demonstrate its success in the future.

3.66 Analysis of data provided by the Hub, for the two months for which we have two years' worth of NICHE data, shows that there has been a

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[10] However, the Briefing Paper in which this is cited does not present the data from which this conclusion is drawn, nor does it explain how it was collected.
[11] This is the Gwent police force's former information management system.
[12] 9 month update for LPU Commanders, p. 1.

small increase in the number of children reported as missing (or absent) between 2014 and 2015. Specifically, between February 2014 and February 2015 there was a 7% increase in the number of missing or absent children and between March 2014 and March 2015 there was an 11% increase. Continued recording and analysis of NICHE data related to missing children episodes in the same month across different years will help to ascertain if this increase has been sustained since February 2015. However, it is challenging to ascertain the extent to which this increase is related to the work of the Hub or if this increase would have been larger had the Hub not existed.

3.67   Case studies included in the Hub's Project Board update reports suggests that of the ten children who went missing most frequently between February and December 2014, four of them went missing less often following the Hub's intervention. In the future, the case studies would be enhanced if the role of the Hub in bringing about improved outcomes is detailed, otherwise it is not possible to attribute positive outcomes to the Hub itself.

3.68   Analysis of ten MIRAFs by Cordis Bright showed that there was a notable trend towards the risk levels of children who the Hub completed MIRAFs for either decreasing or staying the same over time. Although, it is not possible to attribute this positive change or continuity to the Hub's intervention, it reflects promisingly on the work of the Hub in reducing risks for children who go missing.

3.69   The majority of staff and stakeholders felt that the Hub is helping to achieve positive outcomes for children in terms of reducing missing episodes, but only a minority could provide evidence or examples to explain this and many qualified their responses by, for example, explaining that they could not 'put any figures on it'. Thus, while stakeholders and staff tended to report that they believe the Hub is reducing the number of missing children, they suggested that they would feel more able to make a confident judgement if they had access to relevant monitoring data.

3.70   The consultation case studies and the outcomes focused case studies provided some emerging evidence that reduced missing episodes for some children may have been influenced by the work of the Hub. For example, two of the eight consultation case studies provided some evidence that the Hub's intervention helped to reduce the likelihood that the young people would be reported missing again in those cases. While four of the eight outcomes focused case studies reported that missing episodes reduced or stopped since the Hub's intervention, the role of the Hub in bringing this about was not always clear.

3.71   However, the consultation case studies did not provide consistent evidence that the work of the Hub directly resulted in reducing the risk of children going missing or that children did not go missing following the intervention of the Hub. Nevertheless, it is important to note that the case studies portray the experiences of a small proportion of children whom the Hub has intervened with and reflect the contrasting views of those who participated. Rather than revealing the extent to which the Hub is effective in achieving intended outcomes and impacts, the case studies show that the Hub's mechanisms can, and in cases have, resulted in intended changes.

Improving other outcomes for children who go missing

3.72   There is promising evidence, for example, in the outcomes focused case studies and in documentation received, that the Hub, in combination with its partners, is helping to achieve other positive outcomes for children, such as improving educational attendance, reducing risk of Child Sexual Exploitation (CSE), and reduced risk of being victims of crime or harm. In the future, the Hub will be able to demonstrate these outcomes more effectively if it develops its approach to monitoring and performance management in line with the recommendations in this report.

3.73   Hub documentation provides evidence that four of the ten children who went missing most frequently in 2014, have improved other

outcomes, such as reduced risk of CSE and improved educational attendance. However, it would be helpful if the Hub case studies used in the Briefing Reports made it clearer if and how the Hub had brought about these changes.

3.74 Documentation suggests that, at least in its first nine months, the Hub was able to identify more children who were at risk of CSE than would otherwise have been identified and risk assessed, and to refer them to appropriate services.[13] As well as monitoring identification and referral, it would be useful to monitor the outcomes experienced by these children as a result of the Hub's and consequently other stakeholders' intervention.

3.75 A minority of stakeholders reported that the Hub has helped to improve other outcomes for children who go missing, such as reduced victimisation or perpetration of crime. Fewer stakeholders reflected on these outcomes, compared with the number who reflected on the Hub's impact on the number of missing children. This echoes the fact that few stakeholders identified other outcomes as aims of the Hub in section 5.4 of the full report.

3.76 The outcomes focused case studies showed that the Hub is helping to improve other outcomes for children who go missing. For example, the case studies provided evidence in one case that experience of CSE has reduced; in four cases that the young people may have a better understanding to protect themselves against CSE, and; improved family relationships were reported in four case studies.

3.77 Consultation case studies provided mixed evidence regarding the impact of the Hub on improving other outcomes for young people. Three of these case studies suggested that young people face a lower level of risk of harm when missing as a result of the Hub's intervention, although three of the case studies show that the young people continue to face a high level of risk when missing. This emerging evidence based on a small sample suggests that the Hub is

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having mixed success in terms of improving other outcomes for children who go missing, but as stakeholders reported, changing the lives and behaviour of children takes time.

3.78   None of the interviews, documents or case studies showed whether or not the Hub has resulted in a reduction in trafficking of children who go missing. As part of a strategic planning process, the Hub should assess whether or not this is one of its intended outcomes and, if so, measure the extent to which it is being achieved through its monitoring and performance management.

Variation in Hub impact on children

3.79   The majority of Hub staff and a minority of stakeholders reported that the impact of the Hub varies by level of need. Staff reported that the Hub is currently more effective as a form of early intervention for children who have only gone missing once or twice. Staff reported that the Hub would need more resources to work better with children who go missing repeatedly, and a minority of staff reported that it needs to develop its work in schools and peer mentoring provision to develop its role in primary prevention.

3.80   The majority of Hub staff also reported that that the impact of the Hub varies by local authority. It may be useful for the Hub to analyse engagement by local authority area in terms of level of need (e.g. by analysing numbers of missing episodes) to gauge if impact varies by local authority.

Enabling factors in barriers

3.81   The majority of staff felt that the main factor or aspect of the Hub's work which has impacted positively on missing children is the debrief service and that, in particular, this has enabled positive relationships to be developed with children who go missing because of the fact that it is delivered independently. A minority of stakeholders also reported that the independent debrief service is also a primary factor that enables the Hub to result in positive outcomes.

3.82 Staff who commented on this issue reported that the multi-agency and collaborative nature of the Hub was a major enabling factor.

3.83 Staff and stakeholders who commented on the issue reported that the enthusiasm and dedication of both 'front line workers' and 'the team' has enabled the Hub to make a difference.

3.84 However, a minority of staff reported that aspects of multi-agency working also presented barriers to the Hub achieving positive outcomes. For example, one member of staff stated that: 'It is difficult bringing 5 LAs and multi-agency teams together, their systems, terms and conditions and acceptance by team members of differences'. One hub staff member spoke about the difficulties of obtaining timely information from schools for the completion of the risk assessment tool. This links to the reliance of the Hub on the work of its partners to realise some of its key intended impacts and outcomes.

3.85 Resistance to the innovative and new approach to the Hub amongst some professionals, the wide geographic remit covered by the Hub, and a lack of awareness of the Hub amongst professionals were also mentioned by a minority of staff as barriers facing the Hub. Only one staff member stated that poor attitudes among a minority of police officers presented a challenge to the Hub.

Value for money

3.86 On the basis of the most relevant data reviewed, an estimate of the cost of delivering the Hub for one year is £406,367. It is estimated that more than half this cost is born by other agencies in Gwent which contribute £253,024 in staff salaries.

3.87 In both year one and year two, the Hub itself incurred significantly fewer costs than it had anticipated (£145,008 less was incurred in year one and approximately £132,401 less was incurred in year two than anticipated). We understand from staff interviews and discussions with Hub colleagues that the underspend was subsequently used in both years.

3.88   It is not possible to conduct a robust cost-benefit analysis of the Hub as there is no aggregate quantification of its outcomes. However, one case study suggests that the Hub may have helped to avoid around £18,000 in missing person police investigations in relation to a particular young person. This is likely to be a conservative estimate as it does not take into account other possible savings across the health and care economy.

3.89   The Hub may be able to better demonstrate value for money in the future if it records concrete quantitative outcome data, such as a young person's education or training status prior to Hub intervention and after the Hub intervention. Such data will allow for cost-benefits to be more effectively calculated.

3.90   The majority of stakeholders reported that they think the Hub offers good value for money. Stakeholders suggested that the Hub offers good value for money because it: helps to reduce demand on other services, especially the police; is more efficient than traditional approaches; and is delivered relatively cheaply.

3.91   A minority of stakeholders reported that it is important to take into account that as a form of early intervention, the Hub may uncover unmet needs and increase demand initially. One stakeholder felt that it is too soon to make a judgement. It is important to bear this in mind when analysing outcomes related to the Hub, such as numbers of children reported missing. For example, the Hub may lead to more accurate reporting, which could in turn, potentially increase reports of missing children.

4. Conclusion

4.1 The Hub is an innovative project providing a unique service in relation to children who go, or are at risk of going, missing in the Gwent region. There is evidence that key areas of the Hub's work are being implemented appropriately, such as: the Gwent Protocol, the MIRAF, multi-agency information sharing and the debrief work. However, as highlighted throughout this report, there are also ways in which these strands of the Hub's work could be further developed, especially in terms of strategic planning, monitoring and performance management. Although there is some promising evidence which suggests the Hub is resulting in its intended impacts and outcomes, as recommended, the way in which the Hub is monitoring its impact needs to be developed further in order to consistently demonstrate its value and the extent to which it is realising its intended outcomes. We hope to revisit these issues as part of the summative evaluation.

5.   Recommendations

Strategic planning

5.1   **Recommendation 1:** The Hub should develop a strategic plan. In particular, we recommend that:

- The Hub should develop its 'Terms of Reference' to produce more detailed and consistent aims and objectives in order to ensure that all Hub staff and stakeholders, working in relation to the Hub, understand what it is trying to achieve and can therefore work towards the same goals.
- This should feed into a strategic plan, which could be based on the logic model (outlined in this report) for the project, which also includes SMART aims and objectives for the activities, outputs, impacts and the outcomes that the Hub is aiming to achieve, along with measures that will be used to gauge progress and success.

5.2   **Recommendation 2:** The Hub should, as part of a strategic planning process, assess how far its balance of activities is aligned to its aims and objectives.

5.3   **Recommendation 3:** The Hub should assess whether or not reducing trafficking of children who go missing is one of its intended outcomes and, if so, measure the extent to which it is being achieved through its monitoring and performance management.

5.4   **Recommendation 4:** Evidence of variation in the Hub's impact by level of need (for example, staff reported that the Hub is more effective in working with lower risk children) should be taken into account when carrying out strategic planning. This will help the Hub to assess how far this variation will or will not enable the Hub to achieve its broader aims and objectives, i.e. if the Hub is not currently as impactful with high risk children this may impact on planning.

Service delivery

5.5   **Recommendation 5:** The Hub should produce basic protocols in the following areas in order to ensure consistent and transparent practice:

- MIRAF process and risk assessment (including definitions of risk levels such as 'catastrophic' or 'insignificant' with examples, as suggested by the MIRAF analysis).
- Debrief process and decision-making, including being explicit about any eligibility criteria; mediation process; child sexual exploitation work; and other interventions provided by the Hub/on behalf of the Hub – ideally with timescales and quality assurance processes built in.

5.6 **Recommendation 6:** The Hub should continue to develop the MIRAF by continuing to ensure that (a) all professionals who may benefit from or contribute to it, know about it, and how to use it, (b) ensure that MIRAF records are kept as up-to-date as possible, (c) ensure that MIRAF risk assessment matrix data is not over-written so that change over time can be monitored and taken into account, (d) ensure that reasons are provided to explain changes to risk assessments, and (e) technical issues are reviewed and resolved if possible.

5.7 **Recommendation 7**: The Hub should continue to develop its training provision.

- The Hub should ensure that all professionals and carers (including residential homes and hostels) have a good understanding of the Gwent Protocol and, in particular, categories of 'absent' and 'missing' and when to use them appropriately. This may require that more training is delivered.
- The Hub should ensure that professionals are clear about the role of the Hub and their role in relation to the Hub, which will in turn help to avoid duplication. This could be done through continued and increased training and ensuring that professionals are making greater use of the MIRAF where appropriate.
- The Hub should continue to deliver training to as many professionals and carers as possible and, if possible, should consider developing and delivering refresher training. In the future, the Hub should collect more exact figures on the following: the number of staff from all agencies who attended training; and the number of residential units and hostel staff who attended training.

5.8 **Recommendation 8:** There is scope for the Hub to develop its work as a source of primary prevention. As such:

- The Hub should continue to develop its 'Peer Education' work, alongside delivery of workshops for children and families and contribution to schools' education programmes. This will enable the Hub to develop its role as a source of primary prevention.
- The Hub should continue to develop its plans and provision for youth participation work, and to develop plans for providing school children with information, and workshops for parents and carers. This would help the Hub to develop its role as a source of primary prevention and also to engage the target audience of children who are at risk of going missing for the first time.

Monitoring and performance management

5.9 **Recommendation 9:** Llamau and the Hub can continue to improve the delivery of the debrief service and the way it monitors this work through the following:

- The Hub should review the capacity of the debrief service to ensure that it has capacity to meet demand.
- The Hub and Llamau should consider assessing take-up of debrief meetings in comparison with the overall number of children who have gone missing in Gwent, who are eligible for debrief meetings, in the same period, as well as in comparison with the number of those who have been referred to the service. This will provide a more informative impression of the take-up of this service amongst its broad target audience. It would also be useful if Llamau kept a record of and reported on the reasons why some children are not referred to the debrief service. This approach to monitoring will help the Hub understand how far it has engaged with its wider target audience of children who go missing and to assess provision accordingly. The Hub and/or Llamau should continue to report the absolute number of mediation interviews delivered in order to gauge level of output.
- The Hub and/or Llamau could also develop their service user feedback mechanisms in line with SMART targets to assess how far the debrief and mediation service has been effective in meeting the needs of those it works with and if referrals were made appropriately.
- The Llamau reports could analyse the number of debrief sessions provided per child to give a greater sense of the distribution of the debrief service across service users.

5.10   **Recommendation 10:** The Hub should consider developing a more robust quality assurance and management oversight process within the team itself which is not reliant on one key person, in relation to, for example, completion and accuracy of MIRAF reports. This could be done through dip-sampling or developing and implementing stakeholder feedback mechanisms to demonstrate the impact of its work on improving practice. This could include capturing information from stakeholders who are in contact with the Hub. Feedback could include: (a) the background characteristics of the stakeholder, (b) why they were in contact with the Hub, (c) how the Hub helped, (d) how satisfied they were with the Hub, and (e) how the Hub could improve in the future.

5.11   **Recommendation 11:** In order to develop monitoring and performance management across the Hub's work, we recommend that when monitoring and reporting Hub and Llamau:

- collect and analyse data consistently across time
- provide methodological information alongside monitoring data
- collect and analyse the data in relation to intended outcomes, such as analysing missing children numbers in terms of those who are subject to a child protection plan or collecting feedback from debrief service users which relate to what the service is trying to achieve
- report and compare monitoring data against SMART targets to gauge and demonstrate progress and achievements.

Value for money

5.12   **Recommendation 12**: In order to demonstrate value for money and cost-benefits, the Hub should aim to collect concrete and quantifiable data on outcomes achieved for: a) particular children and, ideally b) all of the children that it supports

6.   Appendix 1: Consultation case studies

Consultation case study one

Consultation participants

6.1   The following people participated in the case study:

- One young person was interviewed face-to-face
- Two professionals were interviewed face-to-face separately: a support worker from the supported living setting and his LAC social worker was interviewed.

Person context

6.2   This young person is 15 years old, is looked after under a Full Care Order and resides at a supported living setting. He is currently excluded from mainstream education but received tutoring for two hours per week. They have been missing 12-13 times since August 2014. The following reasons were given by the young person to explain why he goes missing.

- He becomes bored when his television is removed by his carers at 11pm and often can't sleep so he goes out.
- He has a friend who he likes to go out with at night.
- He likes to go out and see his mum.

6.3   The social worker and carer also identified the 'pull factors' of this peer and his mother as reasons why he goes out. They also explained that the following risks are present at his mother's house: domestic violence and possible physical and emotional abuse, child neglect and substance misuse.

Involvement of the Hub in this case

6.4   The young person reported that they had received a timely debrief:

'Once someone from Llamau debrief came to speak with me after I went missing. They came a couple of days after I went missing. They came to talk to me here. It was a bit helpful. They listened to me, gave me information and their number. I can call it if I want but I don't see the point'.

6.5 His social worker and carer confirmed that they aware that he had received a debrief and felt that this was timely. The social worker felt that it was:

> 'helpful as it's good for him to have somebody else to listen to him and speak openly with. It's also helpful that someone is giving him the same messages as me'.

6.6 The young person indicated that there was no further advocacy received from the debrief worker i.e. he was not referred to any other service through the debrief worker.

6.7 The social worker reported that there was not much involvement from the Hub in this case in terms of information sharing as she had been the social worker for this young person for over six years and was fully aware of the risks and issues impacting on his behaviour, although they usually find this (i.e. information sharing through the MIRAF) to be the most helpful element of the Hub's input in other cases.

Other professionals involved

6.8 The social worker did not receive any feedback from the debrief worker following the debrief. The young person felt that professionals generally have a good understanding and that he doesn't have to 'repeat my story' lots of times. However, the young person said that 'It doesn't feel like they work together to help me'. However, the carer felt that professionals, such as the social worker, have the right information and work well together to support the young person.

6.9 The young person, social worker and carer all indicated that the involvement of the police in this case could have been different. The young person felt that the police criminalise him for going missing:

> 'The police don't understand. They treat me like a criminal when I've gone missing. But I haven't committed a crime, I've just gone out when I shouldn't have done. I shouldn't be in trouble with the police'.

6.10 The social worker felt that:

> 'The police get frustrated when we ask them to go and collect him as they don't see him as a proper missing person'.

6.11 And the carer indicated that she did not think the police have a good understanding of the young person's situation, although they did work well with social services. It was not clear whether or not the police were making use of the MIRAF or the information available on it regarding the risks facing this young person.

Impact of the Hub on the child or young person

6.12 None of those consulted felt that there has been any impact on the young person from the involvement of the Hub, either in terms of his likelihood of going missing or his likely experience when missing. The young person, social worker and carer felt that the young person is highly likely to go missing again.

6.13 The young person indicated that he generally feels safe when he is missing and will go to his mother's house if there are any problems. However, the social worker and carer did not feel that the young person knows how to stay safe and avoid harm when missing, indicating that his mother's house is not safe for him.

Areas for improvement

6.14 Neither the social worker nor the young person had any suggestions for how the Hub or related professionals could improve the way it has been involved in this case. The social worker would expect more involvement from the Hub if the young person continues to go missing in the future. The young person's carer indicated that the young person would benefit from an education place.

Consultation case study two

Consultation participants

6.15 The following people participated in the case study:

- One young person was interviewed face-to-face

- The young person's mother was interviewed face-to-face as well as her husband, the young person's step-father

- A professional mediation officer working with the young person was interviewed face-to-face

Person context

6.16   The young person is 14 years old, lives with his mother and step-father at their family home and has a good school attendance record. He has gone missing two times since autumn 2014.

6.17   The reason that the young person and mediation worker gave to explain why he went missing was because of family arguments and not getting on well with his parents. His parents indicated that believe he went missing because he became 'angry', 'confused' and 'does not accept the rules'.

6.18   Other than going missing, the only known risk factor for this young person was that he has stolen twice, although he disclosed this to his teacher soon after. The young person also indicated that he was worried that his school grades have been declining. The young person's mother indicated that he had witnessed some domestic violence as a child.

Involvement of the Hub in this case

6.19   The young person, his parents and mediation worker all indicated that the young person had received a debrief soon after he first went missing. The young person felt that the debrief worker had listened to him, provided him with advice and guidance and *'made me realise the serious side'* of going missing, although he did not feel this changed the way he behaved.

6.20   All of those consulted explained that the young person and his family were referred to family mediation delivered by the Hub by the debrief worker.

6.21   The young person indicated that the mediation worker was helpful because:

'She understood and listened. If she wasn't there it would have been quite awkward for me to talk to my mum about why I went missing. She was helpful and it was easier to talk to my parents with her there. I could say how I felt, how I stood on things. The mediation worker had the best understanding of everybody - she helped me communicate with my family. She did point of the dangers of going missing too'.

6.22   The mediation worker found the availability of information on the young person through the MIRAF helpful because 'I knew if there were historical issues, how he is getting on at school – I had an overall picture'. She said that this information gathering would have taken a lot longer without the MIRAF resource. The mediation worker felt that the MIRAF had helped to 'bring together' all the professionals working around the young person and provide them with the necessary information, especially because he doesn't have a social worker. However, she also indicated that it did not provide as much information as it would have if the young person had a social worker.

6.23   The mediation worker, in partnership with the young person's school, referred the family to Families First and anger management but, at the time of writing, the young person was still waiting to hear the outcome of these referrals.

6.24   The young person's mother described a lack of information sharing and partnership working among professionals: 'We do feel like we have to repeat the story over and over again to different people. The professionals are not working together it's still too separate'.

Other professionals involved

6.25   The young person reported that they had had involvement from the police and their school as a result of going missing. He felt that the first time he went missing the police were helpful and 'great' but that the second time they found him they were 'quite intimidating'. The young person found his support worker in his school helpful because: 'I used to talk to her. She knew my difficulties - I mainly talked to her. She

gave me advice about what to do if you go missing'. But he said he didn't use her advice and that he went missing again anyway.

6.26   However, the young person's mother felt that the school has 'turned its back on him'.

6.27   The mediation worker felt that all the professionals worked well together around him.

Impact of the Hub on the child or young person

6.28   The young person did go missing again after the debrief and mediation according to the mediation officer, but only once. The young person indicated that they feel less likely to go missing again, but that it is still a possibility and that:

> 'I take a day at a time. I don't know if I will run away again or not. I can call [mediation worker] if I need to but I think she has done enough. Even though we've tried to use her advice, we go back to square one. I don't know if she has finished with us yet or not - has she?'

6.29   The young person did not feel that the reason for his going missing had been resolved; he does not feel more supported by his parents and they still have arguments. His mother also did not feel like the mediation intervention had made a difference to the underlying reason for his going missing, stating that: 'It has not made a difference. It has not made much of a difference with his anger and his behaviour'.

6.30   The mediation worker indicated that she 'hopes his risk of missing again has been lowered'. In contrast with the young person and his family, she did perceive the reason for his missing to have been largely resolved as a result of the mediation. For example, she stated that:

> 'His relationship with his step father has improved - they have been able to talk with each other. He is more able to speak to his parents and avoid his trigger factors'.

6.31   However, both the young person and the mediation worker felt that the young person would be more likely to avoid harm and danger if he

does go missing again because he knows to go to his grandparents' house, at any time of the night, if he is missing.

Areas for improvement

6.32 Both the young person and his parents said that they would like more support, such as anger management, Families First or family therapy. The young person said that he would like the mediation worker to visit once per month. Both the young person and his parents were not sure if the mediation intervention had ended or not and suggested that some clarity around this would be helpful.

6.33 The mediation worker felt that it would have been advantageous to make the Families First referral sooner.

Consultation case study three

Consultation participants

6.34 The following people participated in this case study:

- One young person was interviewed over the telephone.
- One social worker (16+ team) was interviewed face-to-face.
- No family member or carer was available to be interviewed in relation to this case.

Person context

6.35 The 17 year-old young person explained that they were repeatedly reported missing from their foster care placement because they were returning home 30 minutes after their curfew, when returning from visiting friends who lived far away. She was reported missing three times in 2014.

6.36 The young person is looked after under a Full Care Order and the social worker highlighted the fact that the young person has a developmental delay and is *'easily led'*. The social worker felt that she would be at risk of sexual exploitation if missing. There were no other risk factors highlighted in relation to this case. The social worker felt that the young person listens well and takes on board advice and guidance.

6.37   The young person has not been reported missing since February 2015.

Involvement of the Hub in this case

6.38   The young person recalled that they had had a debrief which lasted around half an hour. This took place at her home and was timely. She conveyed a positive experience of the debrief and said that the debrief worker was a *'good listener'* and had a good level of understanding. They discussed what was *'reasonable for me'* and what was *'reasonable for my carer'* and what activities she could do in the local area. They spoke to the young person's foster carer too. As a result of these discussions, the young person's curfew was extended from 9pm to 9:30pm. Although the young person said that this was also a result of the involvement of her foster carer's sister.

Other professionals involved

6.39   The young person felt that her teachers in college and her carers are trustworthy and have a good understanding of her situation. She reported mixed experiences of social work support, stating that 'while some have been helpful, others have not been so good, sometimes automatically assuming that they know what is best for me, without listening to me'.

6.40   The young person did not feel that professionals had worked well together to support her. For example, she recalled that her teachers did not attend a meeting with her social workers because they were too busy.

6.41   The social worker was not sure whether or not the young person had previously had a debrief after she had gone missing. The social worker had not used the MIRAF in relation to this case, although she stated that it is useful in relation to other cases.

Impact of the Hub on the child or young person

6.42   The young person reported that *'as a result of the meeting, I stopped coming in late'*. This suggests that the Hub did result in reduced

episodes of this young person being reported missing. The young person also explained that she is now meeting her curfew because: 'I now live with a different foster family, who live much nearer to my friends so I'm not having to come in late'.

6.43 The social worker did not attribute the reduced likelihood and occurrence of this young person going missing to the work of the Hub. Instead, the social worker attributed the reduced occurrence of this young person going missing to the following factors.

- The young person changed foster placement to one closer to her friends and family, making it easier for her to arrive home before her curfew.
- The young person has matured.
- The young person is now spending more time with her aunt.

Areas for improvement

6.44 Neither the young person nor their social worker highlighted any areas of improvement for the Hub or other professionals working in relation to this young person's case.

Consultation case study four

Consultation participants

6.45 The following people participated in this case study:

- One young person was interviewed face-to-face in the presence of her debrief worker.
- Two professionals were interviewed face-to-face at the same time: a school inclusion officer and a family Support team social Worker (seconded from Barnardo's SERAF team).
- No family member or carer was available to be interviewed in relation to this case.

Person context

6.46 This 16 year old young person has not been reported missing since January 2015, although she has not recently had a permanent address from which, or named carer by whom, she would have been reported missing.

6.47   Various risk factors were highlighted in relation to this young person, including: homelessness, substance misuse and sexual exploitation.

Involvement of the Hub in this case

6.48   The young person and family support social worker both reported that the young person had been provided with multiple debriefs after going missing. The school inclusion officer was not aware of the Hub's involvement in this case.

6.49   The young person explained that initially she did not want to engage with the debrief worker because '*I was off my face on drugs*'. However, the young person felt that after she stopped taking the drugs, it was helpful to be able to talk to her debrief worker. She felt that the debriefs were timely and convenient and that she felt 'listened to' and that the debrief worker did not 'speak like above me and she did not speak to me like I was a five year old. Not like my social worker'. She explained that this support from the debrief worker was ongoing.

6.50   The family support social worker explained that she thinks the debrief worker support has been helpful for the young person for similar reasons i.e. that it has provided the young person with someone to talk to who isn't statutory, but is instead independent.

6.51   The young person also reported that the debrief worker helped her access other services and helped her go to her appointments, such as CAMHS.

6.52   The family support social worker did not use the MIRAF in relation to this young person, although she has in relation to other young people. The inclusion officer also has not used the MIRAF in relation to this young person, but she is aware that there is a MIRAF number pertaining to this young person.

6.53   The family support social worker has attended strategy meetings relating to this young person which have also been attended by the debrief worker. She said that the debrief worker contributed well to the plans by, for example, referring the young person to CAMHS and that

'they do even more than they should'. The young person was also aware that the debrief worker *'spoke to my nan and my social worker'*.

6.54   The family support social worker felt that the Hub has done enough to support the young person and that *'they have done the best they can'*.

Other professionals involved

6.55   Other than the debrief worker, the young person felt that her substance misuse support worker and her first social worker had the best understanding of her.

6.56   However, the young person felt that she often had to repeat her story multiple times to different professionals. She felt that professionals *'should have my story on the system, so why do they keep asking me'*. In particular, she did not like being asked to explain herself to professionals she had only recently met, such as police officers and nurses. She felt that at times there have been too many professionals involved and stated that at most, there have been over ten professionals working with her.

6.57   The young person did not report positive experiences of involvement from the police.

6.58   The education inclusion officer explained that she had been able to support the young person to attend a Communities First Aspire programme and also a two day per week apprenticeship at a hair salon.

Impact of the Hub on the child or young person

6.59   The young person reported that she is not going missing anymore because she is no longer taking drugs or drinking. She attributed this primarily to a change in her own *'mind set and thinking'*. However she did mention that during this time her debrief worker and substance misuse support worker *'kept giving me advice and supporting me and helping me stay off the drugs'*. She also explained that she used to text her debrief worker when she felt down or angry.

6.60   Although the young person explained that they are no longer going missing and attributed this partly to the debrief worker. However, the family support social worker and inclusion officer did not feel that issues relating to this young person's going missing had been resolved. They explained that although she has not been officially missing, she has been 'couch surfing' and spending time with the sibling of an older man who was known to have sexually exploited her. They also explained that they believe she is still regularly using cannabis.

6.61   The inclusion officer and family support social worker did not feel confident that the young person would stay safe when missing and instead felt that it is highly likely that she will be a victim of sexual exploitation.

Areas for improvement

6.62   The young person felt that her social worker could improve the way she worked with her because she felt that their relationship revolved around signing paper work and exchanging money, rather than communicating and supporting her. Although the young person does not like the police, she did not have any suggestions for how they could improve the way they work with her. The young person felt that when she was in hospital, her school could have sent her more appropriately pitched work more regularly. She also felt that the course she had been offered since leaving school was not appropriate for her as it was attended by young people with special educational needs and that the school could have offered her an opportunity which was more suitable for her needs.

6.63   The family support social worker felt that there could have been more clarity about the roles of various professionals in relation to this young person, in order to avoid duplication and multiple people asking the young person the same questions. The family support worker and inclusion officer also felt that there could have been more partnership working in relation to this case, as they were unaware of important

aspects of the young person's situation regarding the person who sexually exploited her.

Consultation case study five

Consultation participants

6.64　The following people participated in this case study:

- One young person was interviewed face-to-face.
- A multi-agency focus group was conducted in which the following professionals participated: a sexual health worker (who had not yet worked with the young person); a lead practitioner from Choices, a substance misuse harm reduction agency, who had met with the young person twice; a duty social worker and a student social worker; and a project worker from the hostel where the young person is residing, although he was not the young person's key worker.
- One of the support workers at the hostel where the young person is living was also interviewed face-to-face, although she also was not the young person's key worker.

Person context

6.65　According to the MIRAF, this 16 year old young person has gone missing repeatedly when living at her father's house and is *'almost certain'* to go missing again and faces major risks when missing, including: significant drug misuse, socialising with older friends in other cities. She is also known to have experienced sexual exploitation when missing. However she has not been reported missing since she moved to a supported living setting or since February 2015.

Involvement of the Hub in this case

6.66　The young person reported having had a debrief session around three weeks after she was first reported missing from her father's house. She was given the opportunity to speak with the debrief worker both in the presence of her father as well as on her own. She felt that the debrief worker focused on why she was going missing. The young person said that she did not find this involvement helpful but that she

did feel 'listened to', that the debrief worker 'understood where I was coming from' and that she was given some leaflets about drugs.

6.67 The social workers explained that the initial referral of this young person to social services came from the Hub. However, the social workers had not had any contact or engagement with the Hub in this case since the initial referral. As a result of social services the young person was then referred to sexual health and substance misuse support.

Other professionals involved

6.68 The young person felt that the involvement of Choices, the carers at her hostel and her school has been helpful because they 'have a good understanding of me'. However, she does not think that the involvement of social services has been helpful because they 'tell me where I can go and whose house I can visit'.

6.69 The young person felt that she has had to re-tell her story a few times but that she did not particularly mind this. She felt that sometimes professionals have worked well together to help her. For example, she said that when she went to hospital they worked well together to support her and sort out her benefits.

6.70 The professionals who participated in the multi-agency focus group agreed that the school is not currently being consistent in the way it is reporting the young person missing. The social workers also reported that although the young person has not been reported missing since February, largely because she is telling her support workers where she is going, she is frequently absent and facing significant risks.

6.71 The carer/support workers from the supported living setting conveyed high levels of confusion around when and if they should report the young person missing or whether it is more appropriate to report her 'absent'. The carers/support workers reported that they did not feel confident that the police were ready and willing to 'go and check on her welfare' if they report her absent. They reported that they did not think the police were making enough use of the MIRAF when they have

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reported the young person absent because they don't seem to have the relevant information on the young person and instead go through all of the questions again, which they had experienced taking up to 40 minutes.

6.72 Two of the professionals did not know that the MIRAF existed. The two social workers had heard of it but were not sure what its purpose is or how it can be used.

Impact of the Hub on the child or young person

6.73 The young person felt that she is less likely to go missing now and she reported that the Hub *'did make a difference'* but she did not directly attribute the reduced likelihood of going missing to the intervention of the Hub. Instead, she explained that: *'I have grown up more and I wouldn't go missing so much anymore'*. As well as feeling more *'grown up'* than before, the following reasons were reported by the young person to explain why she is less likely to go missing.

- She is now more likely to tell her support workers where she is so that they don't report her missing.
- She finds it embarrassing if the police go to her friends' houses when she is missing, so she doesn't want to be reported missing.
- One of her teachers has explained the dangers of going missing to her and convinced her of the need to be back at the hostel by a certain time.
- She knows that if she goes missing frequently then she may be asked to leave the hostel and be given a space in Abergavenny which she wouldn't like because it is further away.

6.74 However, the professionals who participated in the focus group all agreed, in line with the MIRAF, that it is *'almost certain'* that she will go missing again.

6.75 There was some evidence that the young person may now have some strategies to avoid harm when missing by, for example, using a straw to take drugs rather than sharing notes. However, overall, the professionals felt that the young person is still at high risk of danger and harm when missing.

6.76   The young person reported that she would like her father to be more involved in her life and that she thinks family mediation could help with this. She also suggested that her social worker could listen to her more and be better at understanding 'where I am coming from'.

6.77   All of the professionals and carers related to this case agreed that all parties need more clarity about when it is appropriate to report this young person 'missing' or 'absent'. For example, one of the support workers from the supported living setting asked: *'Can we report her missing if she is out with people she is not supposed to be with?'* Both carers/support workers at the supported living setting reported that they would benefit from training about how to deal with this missing young person and in particular when it is appropriate to report her missing. The carers/support workers also stated that the police could make more use of the MIRAF and/or that the high levels of risk associated with this case need to be flagged to the police when the young person is reported absent or missing.

6.78   Furthermore, the professionals felt that they would like more of an understanding about what the Hub has done in relation to this case and how it has or could contribute. The two social workers also felt that there could be more awareness and understanding of the MIRAF. One social worker reported that: *'It's both the technical barrier but also the cultural thing of using it. It is a really useful resource but it's not being used enough'*.

Consultation case study six

Consultation participants

6.79   The following people participated in this case study:

- One young person was interviewed face-to-face.
- One carer based at a Llamau supported living setting was interviewed face-to-face.

- Two social workers were interviewed face-to-face at the same time: one Leaving Care Social Worker and one Youth Personal Advisor, both from the children's services 16 plus team.

Person context

6.80 This 17 year old young person resides in a supported living setting and is looked after under a voluntary care order.

6.81 She has been reported missing over thirty times since 2014. However, she has been missing much less frequently recently since she moved to her current supported living setting and was last reported missing in January 2015.

6.82 The risks facing this young person when missing were reported as severe and include self-harm and sexual exploitation.

Involvement of the Hub in this case

6.83 The young person reported that she had a debrief session after she went missing. She said that although she found it patronising at the time, in retrospect she thinks it was helpful. The debriefs were offered soon after she went missing, took up to an hour and took place where she was living. She found that the debrief worker was understanding and a good listener and said that she found it easier to 'talk about my feelings' with the debrief worker than with her social worker. The supported living support worker/carer confirmed that the debrief worker had supported the young person in a timely fashion after she went missing and that they were helpful because it 'was someone just for her'.

6.84 The two social workers consulted indicated that they had been to a presentation about the MIRAF and were aware that the young person had previously had a debrief session after going missing. However, they did not know what the purpose of the debrief was or what it entailed. They reported that they did not feel connected to the work of the Hub in relation to this case. They both stated that they had looked up the information on the young person provided by the MIRAF but reported that they already knew most of that which was available.

They did not think that the Hub contains up to date 'day to day information, such as boyfriends and what is going on with their behaviour'. Similarly, the social workers felt that the Hub's contribution at strategy meetings relating to the young person did not 'add value' because they already knew the information which was shared by the Hub at the meeting.

Other professionals involved

6.85   The young person reported that she has not had to repeat her story multiple times and that professionals have the right information to help her. She found that her social worker has had the best understanding of her and that she works well with her support worker where she lives. However, the young person reported negative experiences of police involvement stating that: 'The police would have a go at me, saying that they are not a taxi service'.

6.86   The young person felt that the support workers at her new supported living setting are much more able to support her than those where she lived previously. She feels that her support worker now is 'like a nanny figure, caring and supportive'.

6.87   The social workers reported that the contribution of the police at the strategy meeting was helpful.

Impact of the Hub on the child or young person

6.88   The young person indicated that she is now less likely to go missing and highlighted the fact that she has only been missing five or six times since she moved to her new supported living setting. She attributed this reduction in the likelihood that she will go missing to the following factors:

- Her current supported living setting is much more calm and supportive than where she was previously living.
- She started talking to her mother again and she said that she doesn't want to disappoint her.
- The young person's boyfriend was allowed to visit at her new residence, so this was no longer such a 'pull factor' for her.

6.89   The social workers also agreed that the support worker at the supported living setting has been the single biggest influence on the young person, reducing her likelihood of going missing again. The support worker/carer commented that her own input along with that of the debrief worker and social worker had led to the young person breaking up with her previous boyfriend who she used to go missing to spend time with. The support worker/carer also suggested that the young person is less likely to go missing now because she currently has a tag.

6.90   The social workers reported that the young person is less likely to be at risk of danger and harm when missing now.

6.91   The support worker/carer felt that the Hub had a strong and positive impact on her ability to support the young person. She reported that the Hub had effectively trained her regarding when it is appropriate to report a young person 'missing' in contrast to reporting them 'absent' and that this helped improve relations with the police because reporting is more appropriate. She also felt that the attitude of the police to missing young people has improved as a result of the Hub's involvement as they are no longer likely to say 'oh well, you're her carer, she goes missing all the time, you go and find her'. As such, she felt that now professionals working around this young person are all 'singing from the same hymn sheet'.

Areas for improvement

6.92   The two social workers suggested that it would be helpful for them if they had a better understanding of what the Hub does and how it can contribute to protecting young people who go missing. They also felt that the approach of the Hub in this case could have been 'more joined up' in relation to their work with the young person to avoid duplication.

6.93   Neither the young person nor the support worker/carer suggested any areas for improvement in the way the Hub was involved in this case.

Consultation case study seven

Consultation participants

6.94   The following people participated in this case study:

- The young person's mother was interviewed over the phone.
- The young person's social worker was interviewed face-to-face.
- The young person did not wish to take part in the research.

Person context

6.95   This 14 year old young person lives at home with her mother, step-father and siblings. She has been reported missing eight times since 2014 and the last time she went missing was April 2014.

6.96   The MIRAF records the following risk factors in relation to this young person: substance misuse, theft, a relationship with a controlling boyfriend. Her biological father is known to have mental health problems as well.

Involvement of the Hub in this case

6.97   The mother was not sure whether or not her daughter had previously had a debrief session. She reported that as there are very many professionals involved in her daughter's case, she was not sure if one of them was a debrief worker. However, she did report that she had spoken to someone from the missing children team on the phone and that they had been 'nice and supportive, because it's nice to know that you are not on your own'.

6.98   The social worker stated that she is aware of the debrief input and availability of the MIRAF in relation to this case. She stated that:

'It has helped and informed the assessment and it is a compact document used to explain the whole period of missing instead of having to trawl through case notes and entries on the system'.

6.99   However, the social worker stated that the CAMHS team had not fed into the MIRAF.

6.100   She also stated that the Hub has contributed to the care planning process on an informal level through phone calls, updates and

sharing risk assessments. She stated that she has discussed her views with the Hub staff on several occasions and that they contacted her to discuss the young person's case when she first became involved. She thought that the debrief worker was helpful because it showed the young person that people cared about her.

Other professionals involved

6.101 The mother conveyed very positive experiences of the involvement of all professionals in this case stating that '*I don't have any complaints really. I think they are all trying their best*'. In particular, she reported that:

'The school have been fantastic. The head of year - she's been brilliant. I'm so grateful that they are still trying - I have a support network. They have been exceptional'.

6.102 She also stated that the school are very well informed about the young person's situation and that they know '*the full picture*'. She also stated that the police have been very helpful and that 'they tell me that it is their job and that they are always there for me'.

Impact of the Hub on the child or young person

6.103 The mother did not know how likely it is that her daughter will go missing again and stated that '*we don't know which way it is going to go*'.

6.104 The social worker reported that the debrief worker helped the young person to understand the dangers of going missing, but that this did not result in a change in the young person's behaviour or likelihood of going missing. The social worker did not feel that the primary reason for the young person going missing had been resolved; the young person was still in a relationship with a controlling and potentially abusive boyfriend. As such, the social worker felt that it is highly likely that the young person would go missing again in the future.

Areas for improvement

6.105 The mother did report that at times she finds it difficult to get hold of her daughter's social worker and that communication with her could be easier. In particular, she felt that social services might be able to

provide some suggestions about diversionary activities for her daughter.

6.106   The social worker suggested that the knowledge and information gathered by all agencies working with the young person should be fed onto the MIRAF, especially CAMHS. She also suggested that the MIRAF is not fully embedded in professional practice yet and is not used as much as it could be. The social worker also identified a gap in services which could appropriately support the young person because there was no specialist service which she could refer the young person to which would help her with regards to being in a controlling intimate relationship. The social worker did not feel that the debrief worker had fully appreciated this as one of the primary reasons for the young person going missing.

Consultation case study eight

Consultation participants

6.107   The following people participated in this case study:

- One social worker was interviewed face-to-face.
- The young person did not want to participate in the research.

Person context

6.108   This 17 year old young person is looked after and now lives with her aunt, although she was given the opportunity to live in a supported living setting. She used to be reported missing frequently because she would stay out more than three nights per week, thereby transgressing the rules of the supported living setting. She was reported missing 13 times between September 2014 and April 2015, although most times she was at a family member's house.

6.109   The social worker also reported that as her location was usually known, the police didn't go and get her, but that as there was no consequence she started to go missing more often.

6.110   The MIRAF states that there are moderate risks associated with this young person going missing, including the risk of substance misuse.

6.111   The social worker reported that the young person had a debrief after she went missing from her foster care placement and that the debrief worker also attended a strategy meeting relating to this young person. The social worker reported that the support from the debrief worker was helpful for the young person because it provided someone to listen to her and someone *'on her side'*.

6.112   The social worker had accessed the MIRAF in relation to this young person and she found the information useful for informing her own assessments.

Impact of the Hub on the child or young person

6.113   The social worker reported that the young person is unlikely to go missing again because she is living where she wants to be – at her aunt's house. She thought that the move to her aunt's house was speeded up as a result of the intervention of the debrief worker and that in this sense the Hub's intervention can be partly attributed as having reduced the number of times this young person went missing.

6.114   The social worker found the involvement of the Hub helpful as through the debrief worker and the MIRAF she was able to access information about the young person that she wouldn't have otherwise had access to. For example, the debrief worker was able to provide more information about who the young person was socialising with when missing. However, the social worker felt that at times her advice and guidance was at odds with that of the social worker and that this did not help in enforcing a consistent message to the young person about where it was best for her to be living.

Areas for improvement

The social worker reported that it would be helpful if she and other professionals had training about missing children and young people and how best to respond. For example, the social worker reported that she did not understand the difference between absent and missing.

# 7.	Appendix 2: Logic model

Inputs, leading to… ➔	Activities, leading to… ➔	Outputs, leading to… ➔	Impact, leading to… ➔	Outcomes
Funding (over a 3 year period): • Big Lottery Fund: £543,202 • Gwent Police: £219,378 • Aneurin Bevan Health Board: £127,264 • Newport City Council: £200,085 • Caerphilly County Borough Council: £58,135 • Torfaen County Borough Council: £49,681 • Blaenau Gwent County Council: £23,024 • Monmouthshire County Council: £18,447 • Welsh Government: £10,800 *7 hub workers*: • Police • Social services • Health • Education • Manager *Debrief service* Independent debrief service provided by Llamau *Training for Hub workers on:*	*Analysis of information and information sharing* • Screen police reports on all children and young people reported as missing/absent and produce Risk Assessments and make referrals to appropriate services. • Collate information and produce comprehensive risk assessments for use by frontline workers when responding to a child reported missing or absent. • Identify trends and problem profiles of missing children and provide this information to relevant stakeholders. • Inform local social services and police about the frequency and gravity of 'missing episodes' where appropriate. *Contribute to case management* • Contribute to the care planning process for 'looked	*Information related* • The number of police reports relating to children missing that have been screened • The number of up-to-date case records • The number of risk assessments and, where relevant, the number of associated home visits/changes to placements • The number of reports which identify trends and key issues • The number of risk assessments produced *Care planning related* • The number of independent debriefings of children who have run away • The number of strategy meetings attended • The number of times the Hub team contributed to care planning meetings *Training for practitioners* • The number of staff who have received training	*Stakeholders[15] working with children who go missing or are at risk of going missing have:* • Improved knowledge and understanding of issues connected to missing children • Improved knowledge and skills to prevent children from going missing • Improved knowledge and skills to respond to, and cater appropriately for, children who go missing • Improved knowledge and skills to prevent children from going missing repeatedly • Improved attitudes to those children who are at risk of going missing or who go missing • Improved attitudes to those children who go missing repeatedly • Better, more accurate information in relation to children who go missing *Children who go missing:*	*Children who go missing or who are at risk of going missing:* • A reduction in the number of missing children • A reduction in the number of missing children who experience harm when missing • A reduction in the number of children running away on more than one occasion • A reduction in the number of children who commit crime or anti-social behaviour when missing • Children who go missing have improved attendance at school • Children who go missing have improved achievement at school • A reduction in child sexual exploitation for children who go missing • A reduction in trafficking of children who go missing • A reduction in the number of children subject to a child

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[15] Stakeholders here include: social workers, teachers, police, health practitioners, foster carers.

Inputs, leading to… ➔	Activities, leading to… ➔	Outputs, leading to… ➔	Impact, leading to… ➔	Outcomes
• MIRAF • Gwent Protocol • MIRAF gateway • Debriefing	after children' and those deemed to be 'in need'. • Referring young people who have gone missing to a Llamau debrief worker ***Facilitating service user involvement*** • In time, the project hopes to train young people as 'peer mentors'. ***Llamau debrief interviews*** • Visit children who have been reported as missing to the police on their return and conduct the 'independent debrief'. These debriefs are designed to provide children and young people with the opportunity to discuss the reasons why they went missing in a confidential, therapeutic and supportive environment and could include family mediation • Provide children and young people with the opportunity to discuss the reasons why they went missing in a confidential, therapeutic and supportive environment which could include family mediation. • Provide advocacy to help children and young people resolve issues that cause	• The number of residential units that have been made aware of the 'Gwent Protocol' and the way it differs from the "All Wales" Protocol • The number of schools who have received support with their education programmes ***Training and support for children, young people and families*** • The number of young people who have received training to become peer mentors • The number of school children receiving information provided by the Hub • The number of young people, carers and parents attending workshops.	• Less likely to go missing repeatedly • Have the knowledge, skills, attitudes and behaviours to remain safe when they are missing • Have the knowledge, skills, attitudes and behaviours to reduce the likelihood of committing crime or anti-social behaviour whilst missing • Have improved attendance at school • Have improved achievement at school • Have their needs met in a timely and appropriate way to address the root causes of why they go missing ***Children who are at risk of going missing:*** • Less likely to go missing • Have their needs met in a timely and appropriate way to address the root causes of why they are at risk of going missing	protection plan who go missing • A reduction in the children who go missing who are looked after ***For funders and tax payers:*** • Financial benefits exceed financial costs resulting in better value for money for funders and tax payers

Inputs, leading to... ➜	Activities, leading to... ➜	Outputs, leading to... ➜	Impact, leading to... ➜	Outcomes
	them to run away and help them access appropriate support services, e.g. Child and Adolescent Mental Health Service (CAMHS), counselling. • Offer a consistent contact in the event of further running away[14] ***Training for practitioners*** • Provide training to those reporting, recording and responding to missing children about what the multi-agency team does, when and how • Work with representatives from the residential units to ensure they have a good understanding of the Gwent Protocol • Contribute to schools' education programmes ***Training and support for children, young people and families*** • Partake in workshops/group sessions with young people and carers or parents			

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[14] This was something that the children consulted considered to be one of the most important but absent aspect of the previous response, *BIG Lottery Application*, p. 24