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Dear David

RE: CHILDREN'S SERVICES AND SAFEGUARDING PEER REVIEW

Thank you for taking part in the Children's Safeguarding Peer Review. The team received a good welcome and excellent co-operation and support throughout the process. It was evident to us all that all those we met were interested in learning and continued development.

We agreed to send you a letter confirming our findings. As you know the safeguarding challenge focused on five key themes:

- Effective practice, service delivery and the voice of the child
- Outcomes, impact and performance management
- Working together (including Health and Wellbeing Board)
- Capacity and managing resources
- Vision, strategy and leadership

Within these overall areas, you asked the team to explore the following issues to assist in your preparation for your forthcoming inspection:

- Effectiveness of early help and front door arrangements, including quality of referrals from partners
- Quality of hand over from front door to children in need
- Quality of practice, planning and supervision for children in need
- Quality of partnership working in impacting on outcomes for children
- Application of thresholds and impact on conversion rates through journey of the child
- How we are ensuring hearing the voice of the child and impact on service delivery

In addition the team considered the progress and impact made since the council's Ofsted inspection of June 2014.

This letter sets out our findings on these areas including the areas of strength identified and the areas which you might want to consider further.

It is important to stress again that this was not an inspection. A team of peers used their experience to reflect on the evidence you presented on safeguarding vulnerable children and young people. The Case Records Review, Case Mapping and Tracking Exercise and Information Health Check, along with the other documentary evidence provided to us, were used in our focus on assisting you in your ongoing improvement.

Executive Summary

It is evident that significant effort has been made in Buckinghamshire to address the failings identified by OFSTED 16 months ago. Additional resourcing by the Council and other agencies presents a clear sign of commitment and the Council has affirmed the priority it gives to children in its Corporate Plan.

There is evidence of some promising practices and approaches. The developments in early help arrangements are welcome and have the potential to make a difference to children and families in Buckinghamshire. Similarly, the MASH development, and specifically the domestic abuse triage and the Swan unit (CSE team), all bode well for the future.

The peer review team was impressed by the work which has gone into developing the Council's relationships with the police and health in particular. Whilst there remains work to do in developing a better understanding of mutual roles and responsibilities and effective working between schools and the council, there are promising signs emerging from the steps which are being taken.

It is also clear that Buckinghamshire wants to do well and is actively seeking support from others to do so.

Notwithstanding this effort, however, there still remains much to do. In some areas such as basic social work practice, progress has been very slow, and the peer review team have considered carefully why more traction is not being achieved in a number of areas. It is the view of the team that there are five aspects which need immediate attention to enable Buckinghamshire to make faster progress:

1. Culture, Behaviours and Values

We feel there is merit in the Council and its partners being clear about the culture, behaviour and values you wish to establish and the role of leaders at every level in modelling these.

We were impressed by the commitment to change and improve. However, we feel that your progress is hampered by an ongoing lack of consistent acceptance of responsibility by both the Council and its partners for the failures which led to the inadequate judgement by OFSTED. It would help improvement significantly if all parties accepted their part in the problems of the past, and now take responsibility for the future path for children's safeguarding services. Telling this as a compelling narrative to demonstrate how you will impact positively on outcomes for children would help you demonstrate more clearly the passion you have for making a positive difference to the lives of children.

We came across evidence of a blame culture. This needs leadership at the highest political and officer level to address, if you are to ensure that a culture of continuous improvement develops and, that honest conversations can be had about performance. Blame cultures are ultimately risky, because they lead to anxiety and a feeling of lack of safety. This in turn impacts on morale, staff turnover and, therefore, ultimately on the safety of children. We came across instances of disrespectful language which suggested to us that more work needs to be done to build and instil a culture of respect between organisations, professions, individuals and communities.

2. Leadership

We have considered what this means for leadership as the Council and its partners move into this next phase of improvement. There is not yet evidence of strong leadership at every level. Senior council members, officers and partners need to become far more visible with front-line staff on a coordinated and ongoing basis and in a way which is supportive and enabling. The council has already engaged in some elements of this through engaging in work shadowing, for example. Using approaches such as this, joining team meetings, spending time in different teams, seeing what it is like for front line staff and managers will enable you to both hear directly what their experiences and issues are, and also to ensure good understanding of and engagement in the strategic plans. Feeding what you find into the quality assurance arrangements and the monitoring of strategic developments will also help you close the loop.

There is a need for corporate services to act with urgency where they are responsible for actions and to understand the impact they have on protecting children. There was not clear evidence that corporate council services are clear about their role in helping to protect children – for example, the slow progress with addressing the ICT issues, as reported at September Improvement Board. These services need to be challenged just as much as Children's Services, to assess their quality and impact, and to ensure that their cost and prioritisation is supporting improvement in children's safeguarding and providing value for money.

Governance overall requires further improvement. Although there is a comprehensive piece of scrutiny work underway in relation to child sexual exploitation, the committee itself has made variable impact on children's services improvement more widely. Scrutiny is not yet demonstrating its ability to perform effectively, tending instead to

mirror the work of the improvement board without adding extra value. With a range of training and development support having already been delivered, the Council should now consider how councillors and officers can work much more closely with the committee, and the officers supporting it, to bring scrutiny into the heart of the improvement process.

There is a particular need for the Council and its partners to think through and re-articulate exactly what you want for children in Buckinghamshire – to re-communicate your strategic intent and ensure it is turned into operational practice - and to look consistently at service development and quality of practice through this lens. By doing this, Buckinghamshire will be able to assure itself more confidently about the impact it is having on the lives of children.

3. Equality, Diversity and Cultural awareness

We would suggest that consideration is given to enhancing the awareness, knowledge and understanding of different cultures and vulnerable groups (e.g. children with disabilities), and the implications for practice and service development across the board. This is not just an issue for Children's Services.

There was little evidence of cultural awareness in case records or in service developments. The performance management system at present gives insufficient information about the needs of different vulnerable groups and impact of any involvement by Children's Services.

We also suggest that the Council and its partners consider how you demonstrate a focus on equality and diversity throughout the workforce and in work with communities. At present, we could not see clear evidence that the Council and its partners knows whether children's services are culturally sensitive or that they meet the needs of the families and communities throughout Buckinghamshire.

4. Consolidation of Basic Practice

From the evidence seen by the peer review team, practice is not yet of a sufficient quality to assure you that your own basic practice standards are being met. There was evidence of drift and delay for some children and families and this should be audited to assess how widespread this is. The transfer arrangements between teams are inconsistent and staff are confused by regular process changes. There is a need for urgent clarity in this area, to avoid delays for children and to ensure all staff in all teams are clear about process and expectations.

Although we only reviewed a small number of cases in the Case Records Review (ten in the advanced two days on-site and a further six in the review week) two of these had to be referred to managers. Appropriate action was taken as a result. We saw a lack of evidence on case records of understanding of the impact of engagement with children's services on the child's life, particularly where access could not be gained to see a child.

Given your unstable staffing situation and the number of handovers you have, we would advise you to consider how to rectify the quality of recording the child's voice rapidly.

We would also urge you to reflect on and clarify your preferred model of social work practice. Whilst many could articulate Systemic Practice and understood this as a way of working in Buckinghamshire, others could not do so. It appears that Systemic Practice is used in CIN teams but not Assessment Teams; this creates a level of confusion for staff in the service but also for children, their families and professionals in other organisations.

5. Self-knowledge to Drive Improvement

We would advise you to give further thought both to improving the accuracy of data, but also to interpreting it more fully, considering what the data tells you; not only about compliance, but also about the impact you are having on children. For example, whilst it is clear you have made progress in some areas of performance, you are not yet consistently asking questions about why there is a gap in achieving a performance standard and how you can narrow it. A good example would be the quality of practice as evidenced by audits. Whilst your focus on moderating the audit judgements has been appropriate, this now needs to move into articulating what the practice improvement themes are, in all judgement gradings and setting out with staff, how the loop is going to be closed.

There are issues where your own assessment is more positive than ours – for example, in the voice of the child work. We also saw examples where performance monitoring and challenge could helpfully be more granular in nature. For example, case allocations are reported as being at 100%. However, this included at the time of our visit, 96 cases allocated to managers. This was not clearly articulated in the meeting papers or minutes which we saw. This makes it difficult for you, the BSCB and the Improvement Board to judge whether the children and families are receiving prompt intervention and support. It also means that managers may not be focusing on the work they should be doing. Improvement is a relentless activity, which requires strong attention to detail at every level.

We also saw that the connection between the front-line work and strategic plans is not evident in all areas. You have developed a suite of strategies that contain a clear articulation of strategic intent. During our visit however, it was apparent that there is still much to do to translate this strategic intent into operational terms for front-line practitioners, in a way that enables them to reflect on the quality and impact of their practice and to understand how the work they do is leading to strategic change.

The new permanent head of service team, gives you greater capacity to bridge this gap as would the further development and strengthening of your front-line managers. A robust self-assessment document would also help develop this further.

Recommendations – things to do urgently

- Agree and role model cultural values and behaviours across senior management, members and partners which will positively impact on staff morale

- Process Map the totality of the child's journey and clarify that systemic practice is used across the service and share this so everyone understands the approach and the methodology

- Clarify what you are calling your 'front door' and embed a team approach to MASH across the partnership under the leadership of a single manager with specific performance targets and flow data, and with the alignment of posts such as the Early Help 'advisor' and the Education Advice services

- Establish a clearer timescale for a) triaging of contacts in the MASH (prior to becoming a referral) to ensure the right children are referred and b) in the First Response Assessment Team so the assessment itself becomes an intervention which could reduce unnecessary referrals into CIN Units which will help manage demand further

- Develop Recording Guidance and Expectations to support improvement and development

- Clarify the critical path for the programme of change, so that staff and partners are clear about the order that changes are going to happen so can see more clearly what is to come as well as what has happened.

The table below highlights the good practice noted by the peer review team and areas for consideration by Bucks and its partners:

Effective practice, service delivery and the voice of the child	**Strengths** • There have been some changes in management and many bring new ideas and a heightened level of enthusiasm and energy. These managers share a clear vision but appear to be working in isolation. The recently appointed Principal Social Worker is developing the Quality Assurance Framework. • There is a clear supervision policy in place and staff at all levels reflected positive experience of effective supervisory meetings. • Family Resilience Teams make use of Family Outcomes Star to better gauge the outcomes achieved. This brings particular focus to the voice of the child and young person in that they have a specific "My Star" and "Teen Star" tool and can be helped to articulate wishes and feelings. • Development of a clear methodology is in discussion in Child Protection and consideration of a range of models and tools such as Signs of Safety and Strengthening Families. • Positive partnership working is evident and a belief that safeguarding is everyone's business has been articulated across all partners. Police identify safeguarding at the top of their agenda. • There is some good school attainment for Children in Care with attainment at GCSE being above the national average. • Health has examples of working with Young People to explore missed appointments and have also developed a good self-harm pathway. • Work is underway with Barnardos around CSE. • There are some good examples in all agencies of articulating the voice of the child, including in some of the case records reviewed, and within child protection conferences. **Areas for further consideration** • The child's journey through the service is unclear. Both CIN and CWD are using systemic practice, but whilst they describe using the systemic model this does not appear as a clear thread through the system. It is neither used nor understood by MASH and First Response (Assessment Team). This leads to families experiencing different ways of working and different use of terminology. This is compounded by some internal teams' lack of understanding for other teams' roles and functions. Partners are confused by MASH First Response and First Response Assessment. • The delivery model for some children has a significant

	number of teams involved and impacts on the number of people working with individual children. • Arrangements for 'out of hours' placement searches are not currently effective with recent difficulties evident. Whilst changes are reported to be underway, current practice of a placement team finishing at 5.30, multiplicity of paperwork for each placement and examples of needing to use Google to access foster agency details as a last resort all need urgent action both in terms of safeguarding and value for money. • Cultural awareness and competency is limited with a lack of understanding of cultural need. Children of different ethnicity are placed with white families when there is a shortage or lack of appropriate placements, with insufficient assessment of cultural needs. Whilst it can be appropriate to place children of different ethnicity with white families, such placements need to be underpinned by a clear assessment of the child's cultural needs and a commitment by the family to meet those needs with support provided. Continue to build an appropriate range of foster carers from the different ethnic and cultural backgrounds to meet the needs of children coming into care. Children's case file records do not explicitly consider their cultural needs. • There is variability around how the voice of the child is understood and how this is documented across the partnership. Whilst case records show some improvement, inconsistencies remain. • Management oversight on case files is inconsistent across teams. Generally, files have a sign off signature and a brief one line to evidence the managers' support, and most are out of timescale. There is little oversight between supervision meetings. There is no evidence of recorded management oversight where students are undertaking Child Protection tasks. • The use of Family Outcome's Star tool is a significant contributor to good practice in this area for the Family Resilience Teams, however there does not appear to be a single comparative tool that can be referred to consistently within the records of other parts of the service, which then links to an overall model for social work practice. There is some reference to the "3 houses" tool but this is variable. • Analysis of data does not sufficiently inform practice. The data provided on the scorecard demonstrates numerical understanding of the work being completed and it identifies gaps of a statistical nature. However, the data does not yet reflect a mature and more qualitative understanding of needs, the provision and allocation of resources or the profile of the population. The learning from data does not

	appear in feedback to staff and it remains unclear how staff are enabled to interpret, in particular, data about their own cases and caseloads to assist with improving practice and, perhaps more importantly, outcomes. • There is no overarching quality assurance framework across the Council. Therefore it is difficult for trends and themes to be measured across the service or indeed wider and into the BSCB. • Audits of some cases found to be inadequate are checked again, but there does not appear to be such an action from those "requiring improvement" or any actions identified on cases graded 'good'. • There is very little evidence of multi-agency risk assessments. Staff referred to these in terms of a risk situation or risk to staff but not in terms of the risk to a child. No training has been undertaken on the new risk assessment.
Effectiveness of early help and front door arrangements, including quality of referrals from partners	**Strengths** • The MARF (Multi-Agency Referral Form) is universally used by partners to refer to social care and early help, and they find it easy to use and succinct. Buckinghamshire NHS Trust trains all its staff to use the MARF in conjunction with the threshold document. They helped design the process and audit the quality of the referral internally and via the multi-agency group audit function. The form captures the risks as well as the family strengths and helps to shape thinking. • The 'one Front Door' has begun to help clarify process for other agencies. The threshold document has increased understanding of appropriate referral. • Strengthening early help and good attendance from partners has helped establish an early help offer. Whilst in its early days, partners attend and chair the early help panels and enable challenge at a strategic level. • In the MASH the commitment and co-location of agencies has assisted information exchange. Calls have a quicker response time, and some partners have seen improvement in feedback on referral outcomes. Three nurses have recently been recruited to cover the MASH. • Taking a multi-agency approach to the development of the threshold document has assisted the process and understanding. We saw some incoming referrals from partners of a good quality and used alongside the thresholds document. • Education appreciates the Education Consultation and Advice service. Schools are able to talk to a dedicated, knowledgeable consultation service that can help them navigate their way into social care. They also help broker any difference in view and provide training.

	• Domestic violence triage is an innovative approach which supports referrals and work is underway to evaluate its impact. **Areas for consideration** • Panels for Early Help are still at a developmental stage and would benefit from further work. More clarity is needed on how and when to access the panels. There are no clear recording mechanisms on case records and no evidence of the impact of the panels can yet be seen. The frequency of the panels is fortnightly. This is being reported as unhelpful if cancelled as that builds in delay for families. During the review, one family was reported as waiting for two months, which lead to them experiencing a crisis and having to be re-referred for social care intervention and support. There is no clear mechanism to monitor timeliness of access to panels. • Whilst it is reported that the MARF is being used and understood, quality remains inconsistent. It is recognised this is an area of development. • Families report not wanting the MARF as it is more directed to Social Care than Early Help, therefore wording on the MARF could be considered further to ensure the referral supports families in accessing Early Help without the worry of a referral to Social Care. • Police use the 'occurrence report' process instead of a MARF and this occasionally causes problems with Social Care having to ring in to the Public Enquiry Counter for a Strategy Discussion to be triggered, and also having to obtain consent from the family if it is not evident on a report regarding potential Early Help. • Not all partner agencies report routinely receiving feedback about the outcome of referrals made. • The MASH is in its infancy and still operating as a collection of agencies rather than a co-ordinated team. • Social Care and partners are not clear on the differences between First Response, Assessment Team or MASH and need clarification on what the front door is to be collectively called. • The MASH function and process remain unclear to social care teams and partner agencies who cite staffing issues, lack of educational representation and lack of KPI's amongst their concerns. • The Early Help Panel process and threshold eligibility are not yet well embedded or understood by Social Care teams or partner agencies.
Quality of hand over from front	**Strengths** • Whilst not yet at a good level, contact and assessment timescales have improved, reducing drift.

door to children in need	• Disparities between CIN unit caseloads have been reviewed to take into account geographical boundaries and areas of need. There is commitment from management that this will not negatively impact on the child (i.e. the social worker will not change). • There is evidence of some swift and child focused case transfer/step up between First Response Teams and Children in Care Units, and Early Help to Social Care to initial court hearings. **Areas for further consideration** • The First Response (Assessment Team) to Child in Need is more robust where child protection plans are in place. The same level of robustness needs to be consistent and include CIN cases. • The newly allocated Social Worker is not always at handover meeting. Whilst there is now better consistency of presence at handover points from the newly allocated team, it is often the team manager or a "duty" worker from the receiving team. Parents and partner agencies are not always aware of a new worker. • There is limited evidence of joint visits being undertaken at handover between existing and new workers between first response and CIN. • CIN plans are not always SMART or inclusive, some agencies have reported not being invited to CIN meetings • There is inconsistency between north and south teams in quality of case transfers.
Application of thresholds and impact on conversion rates through journey of the child	**Strengths** • The threshold document is universally understood and used within Social Care and partner agencies. It was jointly developed across partner agencies and uses common language. Partners speak highly of the document and its applicability - it is widely visible and used to inform referrals. • Agencies make regular use of and reference to the threshold documents when considering if a referral is required and what tier of support may be needed. Links between the threshold document and MARF form is observable in health. • The communication of the thresholds document has been good. The Health Trust has briefed or trained each worker who has contact with children. The Mental Health Trust has briefed Adult Mental Health workers and has introduced Think Family. Joint Police and Social Care training of police staff has taken place. **Areas for consideration** • There is widespread awareness of the threshold document in the Police but embedding its use is still work in progress. • Within Children's Services, there is inconsistent application of thresholds between First Response and CIN - it is not

	clear how the document is being used by team managers and Social Workers. • This inconsistency is impacting on the timely transfer and case allocation between teams and examples of recently closed cases escalating to child protection at the point of re-referral. • Contacts resulting in 'no further action', including domestic abuse notifications, are not recorded on the child's record. There is a risk of losing vital information within the child's chronology to inform future decision making. • The police do not appear to be consistently raising (as per the procedure) those cases where three or more low level DV notifications have occurred. This potentially causes a decision to be made on inaccurate background checks. • There is no clear picture yet of the impact of the threshold document in conversion rates.
Quality of practice, planning and supervision for children in need	**Strengths** • There is now a Supervision Policy in place and some good feedback from middle managers and front-line staff on the quality of supervision being given and received. • Partners including Health, CAMHS, YOS and Education have reported good supervision and good access to new Children's Social Care managers for discussions. • Tracking of s20 cases on the new spreadsheet gives good oversight. **Areas for consideration** Ethnicity and diversity is not yet evident in practice or recording. There are examples of culturally inappropriate fostering options being offered, and in one case record there was clear evidence of cultural insensitivity around the plan and expectations of a mother who does not speak English. Also, use of interpreters is inconsistent and evidence of some over reliance on the other parent or the child / children to interpret for parents. Partners also need to consider how ethnicity of children and families are both recorded and audited and considered within their work with families. • Supervision is not consistently recorded on the system either in frequency and content, therefore although this is verbalised as being regular and good there is no consistent evidence of this on a case records. • There is evidence within case records and also from front-line staff that ICPC and RCPC reports are not completed early enough and not shared with family members or the child / young person where appropriate in a timely manner. • Buckinghamshire Minimum Practice Standards do not identify a timescale within which a child should be seen and seen alone following a referral and for assessment purposes.

	• There is limited evidence in Social Care records of consistent and quality supervision being afforded to front-line staff. This is better evidenced within Family Resilience and also in the CIN teams where a "unit" approach gives rise to case discussions that are then recorded; however there is no such arrangement in First Response part of the service. • The IRO has the authority to postpone a review if they feel that the worker present either has not provided an updated care plan in a timely way, or an inexperienced worker, or one lacking case knowledge is sent to the Looked After Children review instead of the allocated worker. These issues together may contribute to drift if not carefully monitored. • Because of the delays in offering an intervention to young people early in process, further consideration is needed around how the Assessment Team functions to ensure children receive intervention from the outset. • Some cases are being held by managers prior to allocation, transfer or closure, with some case record evidence of this being for longer periods. • There is a practice of team managers being the allocated worker where a student or trainee social worker is working a case. This includes child protection cases with evidence of students undertaking visits described as "statutory" visits, when they cannot be as they are unqualified staff. • In addition, six staff waiting for HCPC registration are holding cases (labelled as trainees or students) and again they cannot be holding the role of qualified social worker without that registration.
Outcomes, impact and performance	**Strengths** • There is good educational attainment by Children in Care. Data shows Grades A-C achievements are improving Buckinghamshire children generally achieve well above the national average and 95% of care leavers enter education, employment or training. • The Performance team have an advance work plan to improve the range and quality of key data. Performance reporting has child level data available and a balanced score card approach currently. There are clear plans to ensure data is used to consider demand, throughput and timeliness. New data relating to MASH is being prepared and there is development around the corporate use of Business Intelligence as a corporate data management model. • Monthly case audits are undertaken and reported leading to a better understanding of practice. There is an embedded process of managers completing three audits per month, which are graded accordingly. Findings are collated and reported on.

	• Those 'inadequate' audits which are moderated are re-audited to ensure improvement. There is awareness demonstrated within staff groups that case work is reviewed following audit and recommendations followed up and reported. • The Practitioner Board exists to provide front-line staff with an opportunity to consider the Ofsted Improvement plan and the journey. It provides a direct link between the Improvement Board and practitioners, with a practitioner Chairperson attending both. Feedback mechanisms are evidenced in formal minutes. • Family Outcomes Star assists in measuring good outcomes. Records reviewed demonstrate clear outcomes being measured and discussed with families about the journey and are clearly linked to the assessed needs and associated actions. Evidence in case records of the tool being used to measure a "baseline" position, a mid-point review during intervention and a final position at point of closure. **Areas for further consideration** • The role between PIMS and IRO/CP Chairs is unclear. Tracking the understanding of staff in a variety of settings demonstrated a level of confusion about the quality assurance roles for each of the above, where they overlap and who they should discuss aspects of practice with. • IRO/CP Chairs do not yet audit cases. The audit process does not include these roles and there is no clear evidence of the intent to do so. Reasons for not doing so to date have been articulated; however the QA function of the IRO role in particular is clearly defined in the IRO handbook, *section 2 Core Function, Tasks and Responsibolities 2.9-2.14* (section 25B 1989 Act). • Lessons learnt from SCR, Complaints and Audits are inconsistently used to improve practice. There is no clear performance mechanism or forum through which lessons learned are disseminated to staff routinely. Staff cannot articulate specific messages from recent SCR's. The complaints report does not outline lessons learned and how these should be communicated to improve practice, including in relation to specific complaints from young people themselves. • Senior members are unclear of their role in quality assurance and scrutiny. There is no guidance or policy which indicates the role or responsibilities of elected members in, for example, the quality assurance of case work and they do not currently undertake a quality assurance function in this way. Scrutiny largely repeats the work of the improvement board, rather than being clear of their own responsibilities within the performance framework.

	• There is a heavy focus on data targets rather than data quality and outcomes. Data currently demonstrates numerical targets to be achieved and are set to demonstrate progress (stretch targets). The data position currently does not reflect qualitative outcomes for children, with few mechanisms for "softer" data to be analysed and presented, other than to the improvement Board. • The strands of quality assurance activity within the service are not clearly drawn together into a framework that demonstrates the child's journey, incorporating roles and responsibilities (such as IROs / elected members and the different Boards) and how learning is then used to "close the loop". • The Children's performance system is not yet linked to the wider corporate framework. The corporate performance methodology and system has been halted and there are plans to introduce a new one. Until that time, the children's performance team are using a spreadsheet that is not directly linked to the corporate picture. • Demographic data is not yet fully evidenced and used at every level of performance management. The reporting data set does not include information relating to diversity of the population. For example, the proportion of children from black and ethnic minority groups represented in CP or CIC cohorts, or the understanding of disability type and impact on service planning. • Data validity is unreliable in some areas. There are some performance statistics that are known to be inaccurate. For example the performance data for private fostering shows as zero when there are known cases. Contacts to NFA show as 20% when this is believed to be more like 8%. The difference in the latter was attributed to multiple outcomes being entered or NFA used when the outcome was step down to early help. This demonstrates inconsistencies in recording and practice leading directly to significant reporting inaccuracies which can lead to difficulties in ensuring there is sufficient capacity or to know what the impact on children and families is. • There is no way of knowing if actions from audits are completed, there is no triangulation of this work. Although some 'Inadequate' audits are re audited (moderated) those which 'Require Improvement' or even 'Good' are not moderated to ensure actions are done.
<u>How we are ensuring hearing the voice of the child and impact</u>	**Strengths** • The voice of child is recorded effectively in Early Help. • The RuSafe project engages with vulnerable young people and considers their needs. • Public Health has completed a large scale survey.

on service delivery	• CAMHS has worked with young people to develop a non-attendance policy at appointments. • Feedback from young people is taken after each visit to A&E. • Young people are involved in the tendering process for new services. **Areas for consideration** • The voice of child is less well captured in Children's Social Care records, there are some inconsistencies in this area • Being clear on the Social Work Methodology would support this area further, having a methodology that is used from the front door all the way though will enable a more consistent approach for children and their families and enable their voice to be heard and recorded consistently.
Working Together and Health and Wellbeing Board	**Strengths** • BSCB has a developing a set of priorities with strong partnership engagement and there is some evidence of impact and challenge between agencies. • The work of the relatively new Chair and BSCB manager has been to revitalise the sub groups via leadership, plans and activity and to build connections to other partnerships and boards. • Additional resources have been allocated to fund the Business Unit. • The Boards Governance protocol clarifies the safeguarding responsibilities of different Boards and the annual meeting between chairs to coordinate and plan emerging issues. • There is strength of feeling from all agencies that the safeguarding of children is a priority and they are all committed to working collaboratively. The leadership and membership of BSCB is seen by partners as strong. • Multi–agency training is well regarded and cascaded across the system. A number of agencies are keen to be part of the training delivery and we heard evidence of the impact of the training from School Governors - for example managing allegations against staff' and safer recruitment and from Third Sector providers - for example child sexual exploitation. • The BSCB support sub group for communications have created a short advert (in partnership with the Adult Safeguarding Board) to go into local cinemas and have developed cards for the public depicting the role of various boards **Areas for further consideration** • The multi-agency data set to support the improvement work needs further development, via appropriate analysis, to enable assessment and understanding of the impact of the overall partnership approach.

	• It was reported that there continues to be a perception that agencies blame and do not always support each other around partnership working when another agency is in the spotlight for poor practice. The challenge for Buckinghamshire and other similar areas assessed as inadequate; is how to turn that perception around to a more inclusive approach which delivers really joined up approaches to safeguarding that are supportive, truly collaborative and focus on the child, not the agency process. You may want to consider how to build on the positive developments with MASH and the willingness of, for example, the Police, to support the Early Help offer, beyond what is the norm for a police service response, to identify other joint projects which evidence strong collaboration to help each other out. • The trust and relationship between schools and children's social care at all levels of the system is improving, but is still stressed. Schools feedback a lack of trust in the competency of social care processes and response, and still report a lack of feedback to referrals. • There needs to be a stronger sense of urgency to deliver change both within the Council and with some agencies. When commitments are made, they are not always delivered promptly and agencies do not always keep each other informed about delays e.g. the sustained presence of a health administrative resource in MASH; development of the social care case work system by Children's Services and corporate IT services. • Whilst the Health and Wellbeing Board considers safeguarding issues, it is not yet consistently considering the commissioning implications.
Quality of partnership working in impacting on outcomes for children	**Strengths** • The recent implementation of the multi-agency SWAN team to tackle Child Sexual Exploitation and its coordination of missing persons, has greatly assisted in the pro-active intelligence gathering and monitoring of potential victims of CSE. The joint siting of police, child social care and Barnados (who undertake the return to home interviews under the RuSafe initiative) close to the MASH, allows for rapid information exchange and decision making around the steps to be taken. There are key operational leads within the council and police; a multi-agency meeting forum to discuss cases and a strategic overview within the BSCB, via a sub-group. • Thames Valley Police and health partners demonstrate a strong commitment to partnership working, quality, information sharing and sharing resources across the system. This can be evidenced by the structural and process

development of the integrated MASH and SWAN teams but the full impact of how this leads to better outcomes for children needs to be developed.

- The school system supported by local authority officers demonstrates a strong commitment to fulfilling their responsibilities to children and ensuring their voice is heard. There is evidence of the value of multi-agency training via feedback from attendees as well as positive support for the access to initial advice that staff receive when dealing with safeguarding issues within their school. There was strong support for the LADO via a number of the school representatives we interviewed.
- The working arrangements within the MASH via the accessibility of the police and social care generally enable prompt decisions to be made around joint or single agency child protection investigations. The MASH has trialed the utilisation of a telephone conference facility for strategy meetings of a more complex nature and needs to develop this further to embed this process within the MASH. Decisions of strategy meetings are recorded promptly to enable appropriate accountability.
- Whilst we did not delve into the internal governance arrangements of partnership agencies their representatives all highlighted that safeguarding was a priority and were able to demonstrate a commitment to both internal and multi-agency governance. However, the most interesting example was the robust governance that took place between the Council Commissioning Team and 3rd Sector providers. This was a positive example of how internal safeguarding procedures were not only scrutinised by the commissioning team but that providers felt that safeguarding was really understood and embedded within the commissioning team.
- The improving quality of agencies as individual organisations is seen as adding quality to overall service provision for the children and young people of Bucks i.e. the movement out of special measures of the local health trust

Areas for consideration

- Due to the recent re-invigoration of the MASH and the recent initiation of the SWAN team they need to be seen as work in progress. The MASH needs to develop until it is operating as one team with a clear set of performance indicators and focus of how it is improving the safeguarding of children within the area. A single manager would enable this. The SWAN team is so early in its implementation that it is difficult to assess its overall effectiveness but the commitment and focus on potential victims of CSE is evident within the team.

	• There was variable feedback on the outcome of referrals by partners to the 'front door'. Some stated that they received an immediate acknowledgement and a follow-up e mail a few days later about a decision; whilst others stated that they did not receive a decision update. This is a fundamental process in engaging partners in making safeguarding everybody's business and needs to maintain a 100% response rate regarding decisions. • Whilst there is an abundance of data available across the partnership safeguarding system we did not see clear evidence of how this was all joined up and analysed and made it possible to report generally on outcomes for children. It is understood that the BSCB Performance and Quality Group are aiming to develop this but you are not alone in finding this a challenge as it's a particular challenge in most areas.
Capacity and managing resources	**Strengths** • Additional resources have been provided to manage capacity and demand including increased management capacity, iPhones for some Social Workers, introduction of Family Outcome Star, and development of the MASH, Early Help Offer and Family Resilience Teams. Police have added resource to the MASH to support the level of DV referrals, thereby supporting referrals in to Children's Social Care. HR are prioritising Children's Services and assisting managers with recruitment and managing agency CVs. • The Children Centres have recently been commissioned and work towards supporting the wider community is underway. The new provider shows promising signs of developing the relationships with social care. • There is positive work by the commissioners including the strategic commissioning document, joint commissioning with outcomes based contracts and clear evidence of safeguarding considerations in the commissioning and monitoring processes • Fifty three managers have undergone 'Coaching to Improve Performance' training, as part of the SE Sector Led Improvement Programme. • Investment in systemic training has been offered and delivered to staff within some teams, this allows for a Social Work approach to be developed • Positive impact of recruitment and grow your own strategy, recent work undertaken in Romania to recruit Social Workers, Retention bonuses have been applied, and more hard to recruit areas like First Response are offered different packages as way to retain and recruit staff. • Corporate communications provided good support to Children's Services over the recent CSE cases

	• Five days of Courageous Conversations events took place in March 2015 with staff from all levels engaged in discussions including values, mission and vision, user journeys and sharing and finding solutions to challenges. Issues addressed ranged from practical issues such as office space, IT and car parking to caseloads, staff morale and the new practicioners board. A repeat event takes place late October. **Areas for further consideration** • Whilst there has been significant investment in front-line services to both increase the number of staff and enhance their skills, it is not yet clear what the impact of this is. • The ongoing concern about caseloads and some of the issues identified regarding allocations combined with an inconsistent reporting by staff of child or family caseload numbers indicates that further work is necessary on the overall capacity needed. Comparatively, the case numbers are not high and a distinction needs to be drawn between target numbers and complexity and the reasonableness of the caseloads held. • Although there has been strong progress in recruiting sixty permanent workers, there continue to be issues with staff retention and recruitment. The service would benefit from further work to clarify why some staff are on different pay to others in some teams, and to clarify how internal appointments are made when there are short term cover or secondment issues. This would build a more transparent culture. • Whilst those staff who had participated in Courageous Conversations were positive about the experience and its value, there was a lack of awareness of its existence from those staff and partners who had not been personally involved. Given the historic position of the low funding of Children's Services, and the issues stated above, greater clarity regarding the medium term financial strategy for Children's Services, and the additional shorter term costs of improvement, would enable the council and its partners to be clearer about the sufficiency of resources overall and be able to judge better whether services are offering better value for money, whether they are provided by the Children's Services, corporate services or by others.
<u>Vision, Strategy & Leadership</u>	**Strengths** • There is evidence of personal and organisational commitment and tenacity. • Children are now a top priority in the Council Corporate Strategy. • Members and officers have positively influenced the

commitment of partners.

- Partners feel able to challenge the Council.
- The positive visibility of the Children's Services Managing Director and his senior team partners has been welcomed by partners.
- There is some evidence of innovative change management approaches.

Areas for further consideration

- Strategic intent is evident, but it is not yet sufficiently understood or owned by the front-line teams. Connection with and regular interaction between and visibility of members and senior managers with front-line teams, which is reliable and focussed on understanding what life is like at the front-line, will begin to bridge that gap. Whilst teams valued earlier experiences of this, several teams and practitioner reported having dates and times for people to come to their team meetings but these were often cancelled at last minute
- Building morale, trust and leadership at all levels. For example, some managers don't feel they can make decisions on cases. This is apparent between case transfers, for example MASH to First Response and First Response to CIN – when the receiving team does not agree with the threshold of the case, they feel that decision around cases is not trusted, causing some disharmony.
- There is not yet a sense of one team, one service approach, unified by a common sense of purpose. No one team was able to say they felt part of a whole system. To ensure change is made and more importantly changes are sustained a sense of one service – one team is needed, within Children's Services, within the Council and within the partnership.
- Significant work is still needed to evidence stronger partnership between Children's Services and education
- The change management approach is not yet engaging and empowering all staff and partners. There remains a tension between too much change and too little change. Whilst this is a common feature of services in intervention, a clearer critical path for change in the project management process could help this.
- The governance by the Council still needs development. Despite the training it has had, scrutiny needs to exhibit stronger and more consistent leadership as a committee. Evidence from committee papers, viewing the committee meetings and from interviews indicates that whilst there have been some promising and more imaginative developments such as the child sexual exploitation work, the work of scrutiny is currently not adding the value it should. It

	is a repetition of the work of other boards in the way it monitors activity, e.g. the Improvement Board. Developing a clear work programme to focus on different aspects of safeguarding improvement, ensuring there is sufficient officer and political support, confidence and drive, and focussing the committee on management oversight considering how the improvement work is impacting on and experienced by children, families and staff in agencies, should enable the committee to operate as a more mature scrutiny function. A time-limited task panel, which would allow scrutiny's work to be more focused and flexible is one option that might be considered in on-going Scrutiny development and support.

Following the team's presentation on 9 October 2015 and the answering of immediate questions, you then ran a prioritisation workshop with a variety of stakeholders. Participants joined one of four tables focusing on Basic Practice, Early Help, MASH and Leadership. The main points that came out of group working at the workshop are recorded in Appendix Three. Whilst specific actions were not recorded in these discussions, a further multi-agency event will be held on 21 October to determine actions following receipt of the draft review letter.

We wish you well with taking your developed priorities forward. The Local Government Association is offering a follow up visit within the next 12 months after the peer review.

This would give us both an opportunity to evaluate the process and assess impact. You and your colleagues will want to consider how you incorporate the team's findings into your improvement plans, including taking the opportunity for further sector support through the South Eastern regional SLI programme or the LGA's Principal Advisor Heather Wills heather.wills@local.gov.uk and the regional Children's Improvement Advisor, Anna Wright.

Once again, thank you for agreeing to receive a review and to everyone involved for their participation.

Peter Rentell
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Local Government Association

Appendix One: Case Records Review

Appendix Two: Information Health check

Appendix Three: Flipcharts from prioritisation workshop