Department for Education Case Review – Buckinghamshire Children's Services

Introduction

John Hyder-Wilson and Suzi Ingram (INGSON Ltd) have been requested in their role as Department for Education (DfE) Improvement Advisors to undertake a review of children's services casefiles in Buckinghamshire. The principal aim of the review was to evaluate whether children are safe, and we will highlight under each case cohort set out below the more detailed and specific factors that were considered and evaluated.

Our Activity

We were on site in Buckinghamshire on Wednesday 13 January, Thursday 14 January, Monday 18 January, Tuesday 19 January and Wednesday 20 January. We met with Buckinghamshire senior managers and others on the afternoon of 20 January (our final day) to give some headline feedback on our emerging findings.

While on site in Buckinghamshire we reviewed a total of 95 pieces of work. These were comprised of 40 contacts into children's services, 20 child and family assessments, 15 child protection enquiries (to include both the enquiry document and the accompanying assessment) and 20 care plans – made up of 10 child in need plans and 10 child protection plans.

All the work reviewed had been undertaken within the last few months since Summer 2015. This was to ensure that our findings related to recent and current practice. We drew our samples randomly from data lists provided by Buckinghamshire colleagues, although we did try to ensure a rough gender and age balance so that the sample was as wide and representative as possible.

We set out our detailed findings below and a concluding section will make some concise recommendations for future practice. All 'days' referred to in the report are **working days** unless specifically stated.

Section 1: Findings

(1) Contacts

1.1.1. We reviewed 40 contacts into the service.

1.1.2. We found that the management decision at the conclusion of the contact for the next step, whether this was for no further action or for an assessment or any other disposal, was generally very sound. We fully agreed with the decision at the conclusion of the contact on 36 matters (or 90% of the sample). We had more some questions with the disposal decisions on the remaining 4 contacts, but these were arguable either way and did not concern the immediate safety of children.

1.1.2. In terms of timeliness, *Working Together 2015* allows 24 hours (or one working day) for decision making on contacts. 26 of the sample reviewed (65%) were processed within one day and the remaining 14 (35%) took longer because of activity within the MASH (multi-agency safeguarding hub) process. This process usually comprised database checks and telephone calls to parents and professionals. Sometimes MASH enquiries added little information and often our judgement was that it was clear at the contact stage – before any MASH process – that an assessment would be required in any case. Care therefore will need to be taken to ensure that MASH enquiries are timely and completed within the 24 hours permitted for decision making.

1.1.3. There are also dangers inherent when speaking to everyone except the child in such circumstances. If a contact comes in relating to a concern about a child and MASH enquiries take place, it is possible that parents and professionals may be spoken to by 'phone to give their account of the matter and then the matter is closed on contact. This means that the only person who has not had an opportunity to give an account is the child him or herself. While we did not see this practice leading to specific problems in this review, we would recommend that this point be borne in mind.

1.1.4. We would summarise this section by saying that practice concerning incoming contacts in Buckinghamshire is generally good, although care needs to be taken over timeliness and the MASH process generally.

(2) Child and Family Assessments

1.2.1. We reviewed 20 child and family assessments (CFAs) and evaluated 6 specific areas of practice in some depth. These are set out and discussed below.

1.2.2. We firstly looked at the threshold for commencing a CFA and whether this was in the right place, i.e. neither too high, meaning that situations of concern with children were not being assessed, or too low which might mean that unnecessarily intrusive work was taking place with children and their families. Once again, we found that threshold decisions were fundamentally sound and were in agreement with 18 of the 20 decisions (90%). Of the other two matters, we felt that one should have been a child protection enquiry (although the child was not left in a position of concerning risk) and the other did not reach the threshold for a CFA after MASH enquiries.

1.2.3. We looked next at whether the child had been seen and spoken to about the issue that had led to the CFA (or clear observations had been made of the child if he or she was too young to converse or was without speech). In 16 matters (80%) the child had clearly been seen or observed in the way described above, and in a further case the young person had refused to see the social worker. In the remaining 3 matters it was less obvious whether the child had been seen and spoken to about the issues in hand because of unclear recording.

1.2.4. Our next line of enquiry concerned the length of the CFA and whether the time taken to complete it was proportionate to the complexity of the issue of concern.

1.2.5. We judged that 11 CFAs were timely and proportionate (55%) and that 9 (45%) were less so. Generally our findings here concerned the length of time the assessment had taken which was often too long. Our standard for measuring the length of an CFA is from the contact date plus 24 hours (as permitted for decision making) to the date of management sign off at the end of the CFA.

1.2.6. Using this measure, 3 CFAs took between 10-20 days, 7 took 21-30 days and the remaining 10 took 31 – 45 days. While all the CFAs in our sample were completed within the 45 day timescale set out by *Working Together 2015,* some should not have taken that long and were relatively brief and uncomplicated assessments. The advantages of a timely assessment are twofold, (a) to ensure a prompt service to children and families and (ii) to ensure that work is flowing through the organisation and that backlogs do not develop.

1.2.7. Our fourth area of interest was whether attributed professional agency checks were present within the CFA. These are important to ensure that known information about the child from identified partner professionals is fully integrated into the assessment adding to the knowledge base.

1.2.8. Full and clearly attributed agency checks were present in 8 CFAs (40%), partial agency checks were present in 7 (35%) and agency checks were missing in the remaining 5 (25%). We hold to a high standard of practice in this important area and so vague and inchoate phrases such as *'it is reported that (the child) is healthy'* or *'no concerns were raised concerning (the child's) education'* do not count as professional agency checks as there is no mention of the source of the information.

1.2.9. Our penultimate area of scrutiny concerned the presence of assessment analysis in the CFAs reviewed. A professional analysis of the information gathered by the author of the CFA is important to ensure that matters such as (e.g.) risk to children or family functioning are carefully evaluated and evidenced conclusions drawn.

1.2.10. Good assessment analysis was present in 5 CFAS reviewed (25%) and a further 5 (25%) had some limited elements of analysis. Assessment analysis was not present in the remaining 10 CFAs (50%) and this section of the assessment was often used to merely summarise the information gathered or alternatively to suggest a care plan. Practice development therefore needs to occur in this area.

1.2.11. We finally looked for the presence of management oversight on CFA documentation in the form of a rationale for the next steps at the conclusion of the CFA. All 20 had a management rationale at the conclusion of the assessment and this was very good practice.

1.2.12. We would therefore summarise CFA practice by pointing to a number of strong elements in current practice. These were principally in the decision making for commencing the CFA, seeing and speaking to children and the presence of a management rationale at the conclusion of the assessment. We would also comment more generally that assessment recording was, in the main, coherent and well constructed. This is by no means always the case in our experience. Areas for improvement include aiming for a greater level of attributed agency checks and ensuring that social workers are encouraged to provide a more confident and evidenced professional analysis at the conclusion of CFAs.

(3) Child Protection (section 47) Enquiries

1.3.1. We reviewed 15 child protection enquiries (CPEs).

1.3.2. We have firstly some comments to make about the formats currently in use in Buckinghamshire for the recording of CPEs. At the current time there is a document entitled Record of Outcome of Section 47 Enquiry (ROS47) which contains the account of the actual CPE. A CFA document is usually opened at the same time and this assessment often runs on for some time after the CPE is concluded and written up on the ROS47. Many local authorities in England operate a similar process to this.

1.3.3. However, this practice poses an immediate problem: that of a potential dual and repetitive process. *Working Together 2015* does not provide altogether clear guidance on this point but *does* clearly state that an assessment is the vehicle for the 'section 47 enquiry'. We think that this is the reason for the recent *de facto* division of the child protection enquiry process into two discrete parts, firstly what has become known as a 'section 47 enquiry' and secondly a partially concurrent CFA. The first is completed in relatively short order and the second can take up to 45 days (or 9 weeks).

1.3.4. The ROS47 document in Buckinghamshire contains headings which allow for the recording of some good assessment information and an evaluation of risk, but is certainly not a complete 'assessment' as it missing important sections relating to parenting capacity and the views and wishes of the child. Perhaps inevitably therefore, some accompanying CFAs contain entirely new information, some are an amalgam of information already recorded in the ROS47 and new information, and some are a virtual cut and paste of ROS47 information. This does not represent either consistency or a lean and clear process.

1.3.5. There is a solution adopted by some local authorities, including those who have been judged as 'good' by recent Ofsted inspections. This is to combine the CFA and ROS47 documents and processes into one brief assessment document – which produces a focused, standalone and combined CPE enquiry and assessment document.

1.3.6. Turning to the strategy discussion (or meeting) which should be held at the outset of all CPEs to plan the enquiry, we were in agreement with the threshold for all of these. This is a simple one – the existence of significant harm or the likelihood of such.

1.3.7. We calculated how many working days it had taken to hold the strategy discussion (SD) from the date of the contact of concern and the results were as follows: in 8 cases (53%) the SD had been held on the same or the next day, in 2 cases it had taken 2 days, in 2 cases 3 days, 1 case 4 days, 1 case 12 days and in the final case, where there had been confused process, it had taken 16 days. In general we would normally expect SDs to be held within 48 hours of the incoming contact and in cases of serious abuse the SD should be held on the same day. Exceptions to this may be when matters of complexity are being investigated which require a full strategy meeting to be convened and where there is no urgent or immediate risk to the child.

1.3.8. The length of time before the child was clearly seen and spoken to following the contact of concern was as follows: in 6 matters (40%) it was on the same day or the next day, in 1 case 2 days, 1 case 3 days, 4 cases 7 days, 1 case 10 days, 1 case 12 days and 1 case 18 days. While no child was left in a situation of unmanageable risk in any of these situations, we would recommend that all children subject to a CPE should always be seen within the first 5 days, or of course much more immediately if there is a need to so.

1.3.9. We noted that there was obvious police involvement in 11 SDs (73%). In 2 further matters it was unclear from the recording and in the final 2 matters, police were not involved. Clearly, there should always be police involvement in all SDs.

1.3.10. The ROS47 document is, as described above, the current format in Buckinghamshire for recording the process and findings of the CPE. Our findings on the use of this document was as follows:

1.3.11. The child was clearly seen and spoken to about the issue in hand in 5 of the 15 matters reviewed (33%) and in 9 matters there was no clear voice of the child (67%), but a good account of the child's views was then contained in the subsequent assessment. 1 child was unborn at the time of the CPE.

1.3.12. 13 matters (87%) contained a clear evaluation of risk and 2 did not.

1.3.13 Information about the child from partner professionals was clearly integrated within the CPE in 13 of the 15 matters reviewed (87%).

1.3.14. Once again, we found ourselves in broad agreement with the outcome decision made by managers at the conclusion of the enquiry process. 6 of these matters progressed to an initial child protection conference, 7 concluded with a decision to continue the CFA, a further matter was referred on to early help services and the final matter was concluded with no further action to children's services.

1.3.15 Clear management rationale for the decision made was clearly contained on 5 documents (33%) while the other 10 (67%) had no such clear rationale. This is likely to be because the ROS47 document doesn't contain a specific place for this recording to be made.

1.3.16. In terms of the timeliness of the CPE process – all in this sample were concluded under 19 days with the average time being around 12 days. This is reasonably timely, although a clear 10 day standard should be considered by Buckinghamshire.

1.3.17 We looked finally at whether the initial child protection conference had been held within 15 days of the SD that made the decision for a child protection enquiry. This is a clear *Working Together 2015* standard. In 3 of the 6 matters (50%) that proceeded to conference the 15 day timescale was met and in the other 3 it was not.

1.3.18. We would summarise practice concerning child protection enquiries by commenting that, on the evidence seen within this sample, children are being protected by the process. Furthermore, specific good practice was noted in management decision making both for the initiation of the CPE and the decision for next steps at its conclusion, although the rationale for the latter was not always clearly recorded on the documentation.

1.3.19. Two areas in particular require prompt attention – these are firstly the documentation used to record the CPE as set out in detail in paragraphs 1.3.2 – 1.3.4 above. The second area that needs to improve is timeliness at various points: in holding the SD; in seeing children during the CPE; in the length of the CPE; and in holding the initial conference within 15 days. While none of these areas were of critical cause for concern, a general tightening of the CPE process (which would be much assisted by a more streamlined business process and associated reduced documentation) is required.

(4) Care Planning

1.4.1 We have a number of comments to make about the care planning format used in Buckinghamshire for both child in need (CiN) plans and child protection (CP) plans. The format used is a remnant of an old ICS system where care planning is split potentially into three main assessment domains and numerous sub-dimensions – although generally only the 3 domains, i.e. (i) child's developmental needs, (ii) parenting capacity and (iii) family and environment are now used. However, we did find that occasionally planning information was still contained in the sub-dimensions of these 3 main domains.

1.4.2. Inside the separate planning domains, the same planning grid is used for each which has three headings: What Needs to be Done, Outcome and By Whom and When. This can produce clear and focused care plans if used properly. Sometimes however vague, general and unspecific information and tasks (e.g. 'monitoring the ongoing impact of….') is being placed within the grid, and additionally the boxes are not always used correctly. Clear timescales for actions identified were usually missing in the cases reviewed.

1.4.3. We are passionate advocates of clarity, simplicity and specificity in care planning and believe that this is important for many reasons, including the creation of a sense of purpose with clear 'finish lines' which are readily understandable to both professionals and children and their families.

1.4.4 Our standard for all care planning whether with children subject to CP plans, CiN plans (or planning for children in care) can therefore be simply stated. Clear and specific **needs** should be identified which should feed into clear and specific desired **outcomes** which set the 'finish line' of professional involvement. The **detailed planning** then focuses on what needs to happen to reach each desired outcome, including the timescales for involvement and people responsible. An example may be helpful here:

Identified Need	**Desired Outcome**	**Detailed Plan**	**Who responsible and due date**
Philip needs to live in a house free from domestic violence	Philip is living in a house free from domestic violence	(1) CAMHS to continue working with Philip concerning the impact on him of witnessing violence between his parents. (2) Mr Smith (father) to attend the probation group for men who have committed acts of domestic violence (3) Mrs Smith (mother) to attend the next women's aid victims' group programme.	(1) Ashley Brown, CAMHS psychologist to continue this work and provide a report to the RCPC on 12/4/16. (2) Fiona Jones, Probation Officer to arrange. Report on progress to come to the RCPC on 12/4/16. (3) Tim White, social worker to find out when the group commences and pass the details to Mrs Smith by 29/1/15.

1.4.5. Managers must therefore be vigilant in their quality assurance role and pass back plans which are vague and unspecific and which do not contain clear outcomes and timescales. The overuse of words such as 'ongoing', 'monitoring', 'engage' and 'liaison' are often early warnings of incipient planning drift. There is some good and focused care planning occurring in Buckinghamshire at the current time, and the format is better than some we have seen, but as a general rule of thumb plans need to move further in the direction of outcome focus and specificity, particularly concerning timescales for actions.

1.4.6. The Buckinghamshire visiting standard for children subject to Child Protection Plans is currently a high and rigorous one of visiting and seeing the child every 10 working days. We think that is the correct standard.

1.4.7. We looked at the **statutory visit exemplars only** (entitled 'Statutory Un/Announced Visit – non CLA') for evidence of CP visits and checked whether the child was seen on each of these. 2 were strictly compliant with the 10 day timescale and 8 were not. We would comment that visits were often not far out of the 10 day timescale, but gaps did exist.

1.4.8. This exemplar was sometimes used even when child was *not* seen. We would strongly recommend that this particular exemplar is only used if the child is actually seen.

1.4.9. After some debate with senior managers about what precisely constituted management supervision on cases, we have counted the following two events as evidence of planned staff supervision. These are, firstly notes of a traditional clear 1:1 supervision between the manager and the allocated worker, and secondly a full unit discussion with clear notes setting out the discussion and any decisions flowing from it. This is a less traditional model of supervision, but we accept that this model is well embedded in Buckinghamshire and provides a good and structured opportunity for discussion, reflection and decision making, albeit in a format of a group rather than a 1:1 discussion.

1.4.10. We have not counted the many entries on casefiles where managers have recorded decisions on a single issue, or have summarised their thinking on a case. Such notes are present on many cases and indicate good management overview, but are *not* indicative of 1:1 or unit group supervision. Using this strict definition, 6 CP cases were supervised monthly and 4 had some gaps in supervision. We would further recommend – as it is difficult to be absolutely definitive about which notes indicate 1:1 supervision and which some other process – that the numerous headings for management overview on casefiles are rationalised, slimmed down and made clearer.

1.4.11. There was evidence of clear progression of the CP plan, (drawn from the core group notes, the review conference minutes, or the changing plan) in 5 cases (50%) and there was little evidence in the other 5. In the matters where little change was evident either the actual plan was not changing, or the core group minutes just contained 'update' information not closely linked to the progression of the plan.

1.4.12. The standard for visiting children subject to child in need plans is 4 weeks or every 20 working days in Buckinghamshire and once again we were in agreement with this clear and relatively frequent standard.

1.4.13 Looking solely at the statutory visit exemplar ('Statutory Un/Announced Visit – non CLA') for evidence of CiN visits, 6 cases showed evidence of regular visiting within the set timescale of 20 days and 4 had gaps.

1.4.14. We used the same definition as outlined in paragraphs 1.4.9. and 1.4.10. above for evidence of staff supervision and judged that on 7 CiN cases (70%) supervision was regular and the remaining 3 had gaps in supervision.

1.4.15. There was evidence of clear progression of the CiN plan, (drawn from CiN meetings or the changing plan) in 6 cases (60%) and there was little evidence in the other 4. In the matters where little change was evident either the actual plan was not changing, or the child in need meeting minutes simply contained 'update' information which was not closely linked to the progression of the plan.

1.4.16. We would summarise practice in this area by stating that the planning format could be simplified further and it will be important that social workers and managers work to ensure that planning becomes more focused, clear and specific. A lack of clear focus, planning drift and extended over-involvement are usually the consequences of poor or unclear care planning. We saw examples of planning that were clear and specific and also of planning where much greater clarity was required.

1.4.17. Levels of visiting children and of staff supervision were reasonable, although do not quite match the standards that Buckinghamshire have set for practice in the CP and CiN areas. While we did not uncover concerning gaps where children had been left unsafe, it will be important that further improvements are made in this area. We would also recommend that 1:1 supervision on child protection cases between a manager and a social worker (as distinct from a discussion in a unit meeting) should occur at least once every 8 weeks, i.e. every other supervision.

Section 2: General Summary

2.1 Senior managers have a good level of knowledge and insight into social care process and practice and we found during our time on site that several improvements to some of the matters described in this report had already commenced prior to our involvement (e.g. in speeding up the MASH process and streamlining the CPE process). There is a real tangible sense in the current senior management team that although there is still much to do – and that matters had been extremely difficult in the recent past – that the improvement task was achievable and would be completed.

2.2 Drawing on our wide experience of other local authorities, we would say that this is not a chaotic, unmanaged environment which is not focusing on children and where endemic, embedded and unchallenged poor or dangerous practice exists. We did not come across any children in our sample who had been left in obviously dangerous situations and the thresholds for the various social care interventions are in the right place from the evidence that we saw. In many areas of activity, as noted, strong practice and performance exists.

2.3 However, there is still clearly much to do to improve social care practice and services to children and their families further and the areas for attention are in connection with the gaps that we have identified both in current practice and in making social care processes more lean and fit for purpose. As we have said, simplification is needed in the child protection enquiry and care planning processes to ensure that greater clarity of process and purposefulness of intervention is encouraged and in place.

2.4 Professional practice needs to improve in areas such as assessment practice (e.g. in assessment analysis), clear care planning and in the demonstration of a greater level of compliance to internal standards for visiting children and the supervision of staff.

2.5 We hope that the observations and recommendations made in the various sections of this report will both be helpful and of practical use and assistance in the months ahead.

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INGSON Ltd: appointed Department for Education Improvement Advisors

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Principal Sources

Working Together to Safeguard Children 2015: HMSO London