Buckinghamshire County Council

Select Committee

Children's Social Care and Learning

Date: Tuesday 23 February 2016

Time: 10.30 am

Venue: Mezzanine Room 2, County Hall, Aylesbury

AGENDA

9.30 am Pre-meeting Discussion

This session is for Members of the Committee only. It is to allow the Members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

10.30 am Formal Meeting Begins

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE**		
2	**DECLARATIONS OF INTEREST** To declare any Personal or Dislosable Pecuniary Interests.		
3	**MINUTES** Minutes of the meeting held on 3rd November 2015.		5 - 10
4	**PUBLIC QUESTIONS**		

Public Questions is an opportunity for people who live, work or study in the county to put a question to a Scrutiny Committee about any issue that has an impact on their local community or the county as a whole.

Members of the public, who have given prior notice, will be invited to put their question in person.

The Cabinet Member and responsible officers will then be invited to respond.

Further information and details on how to register can be found through the following link and by then clicking on 'Public Questions'.

http://democracy.buckscc.gov.uk/mgCommitteeDetails.aspx?ID=788

5 CHAIRMAN'S REPORT

For the Chairman of the Committee to provide an update to the Committee on recent scrutiny related activity.

6 COMMITTEE MEMBER UPDATES

For Members of the Committee to provide an update on any issue they are investigating on behalf of the Committee.

7 CABINET MEMBER UPDATES

i) Cabinet Member for Children's Social Care & Learning

ii) Cabinet Member for Education & Skills

8 PREVENT AGENDA **11 - 16**

To consider the work underway to prevent the radicalisation of Buckinghamshire children and young people.

Attendees

Zahir Mohammed, Cabinet Member for Education & Skills
Lin Hazel, Cabinet Member for Children's Services
Yvette Thomas, Policy & Equalities Manager

9 DEVELOPMENT OF THE CHILDREN'S SOCIAL CARE & LEARNING BUSINESS UNIT UNDER THE FUTURE SHAPE PROGRAMME **11:15** **To Follow**

To evaluate the proposals, their implementation and their impact on business as usual.

Attendees

Zahir Mohammed, Cabinet Member for Education & Skills
Lin Hazel, Cabinet Member for Children's Services
David Johnston, Managing Director, Children's Social Care

& Learning Business Unit

10 UPDATE ON CHILDREN'S SERVICES IMPROVEMENT **11:45** **17 - 52**

Following the Local Government Association Peer Review, the Department for Education audit and subsequent revision of the Improvement Plan.

Attendees

Zahir Mohammed, Cabinet Member for Education & Skills
Lin Hazel, Cabinet Member for Children's Services
David Johnston, Managing Director, Children's Social Care & Learning Business Unit

11 DATE OF NEXT MEETING

To note the next meeting of the Children's Social Care & Learning Select Committee on 12th April 2016.

Purpose of the committee

The role of the Children's Social Care and Learning Select Committee is to hold decision-makers to account for improving outcomes and services for Buckinghamshire.

The Children's Social Care and Learning Select Committee shall have the power to scrutinise all issues in relation to the remit of the Children's Social Care and Learning Business Unit. This will include, but not exclusively, responsibility for scrutinising issues in relation to:

- Nurseries and early years education
- Schools and further education
- The Bucks Learning Trust
- Quality standards and performance in education
- Special Educational Needs (SEN)
- Learning and skills
- Adult learning
- Children and family services
- Early intervention
- Child protection, safeguarding and prevention
- Children in care (looked after children)
- Children's psychology
- Children's partnerships
- Youth provision
- The Youth Offending Service

* *In accordance with the BCC Constitution, this Committee shall act as the designated Committee responsible for the scrutiny of Education matters.*

Webcasting notice

Please note: this meeting may be filmed for subsequent broadcast via the Council's internet site - at the start of the meeting the Chairman will confirm if all or part of the meeting is being filmed.

You should be aware that the Council is a Data Controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with the Council's published policy.

Therefore by entering the meeting room, you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If members of the public do not wish to have their image captured they should sit within the marked area and highlight this to an Officer.

If you have any queries regarding this, please contact Member Services on 01296 382876.

If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

For further information please contact: Reece Bowman on 01296 382548, email: rebowman@buckscc.gov.uk

Members

Mrs M Aston
Mrs P Birchley
Ms J Blake
Mr D Dhillon (VC)
Mr P Gomm
Mr P Irwin
Mrs V Letheren (C)
Mrs W Mallen
Mr R Stuchbury
Mr D Watson
Ms K Wood

Co-opted Members

Mr D Babb, Church of England Representative
Mr M Moore, Roman Catholic Church
Ms M Nowers, Primary School Sector

Buckinghamshire County Council
Select Committee
Children's Social Care and Learning

Minutes

CHILDREN'S SOCIAL CARE AND LEARNING SELECT COMMITTEE

Minutes from the meeting held on Tuesday 3 November 2015, in Mezzanine Room 2, County Hall, Aylesbury, commencing at 10.00 am and concluding at 12.02 pm.

This meeting was webcast. To review the detailed discussions that took place, please see the webcast which can be found at http://www.buckscc.public-i.tv/
The webcasts are retained on this website for 6 months. Recordings of any previous meetings beyond this can be requested (contact: democracy@buckscc.gov.uk)

MEMBERS PRESENT

Dev Dhillon (Vice-Chairman), Phil Gomm, Paul Irwin, Valerie Letheren, Wendy Mallen, Robin Stuchbury and Katrina Wood

CO-OPTED MEMBERS PRESENT

Michael Moore

GUESTS PRESENT

Mrs. Lin Hazell and Zahir Mohammed

OFFICERS PRESENT

Carol Douch, Simon Rose and Yvette Thomas and Reece Bowman

1 APOLOGIES FOR ABSENCE

Apologies were received from Mrs J Blake, Mr D Babb, Mr D Watson.

2 DECLARATIONS OF INTEREST

No declarations of interest were made.

3 MINUTES

The minutes of the meeting held on Tuesday 22nd September 2015 were agreed as an accurate record.

4 PUBLIC QUESTIONS

There were no public questions.

5 CHAIRMAN'S REPORT

The Chairman updated the committee on the following:

- The Department for Education are due to visit social care soon to give their assessment of whether or not services are improving
- An LGA peer review team visited social care at the start of October and a verdict is expected from them shortly
- The Chairman, Miss Wood and Mr Bowman visited a foster carer on 19th Oct
- The Chairman and several other committee members had visited the Buckinghamshire Learning Trust on 20th Oct to meet the senior team and hear about what work is underway

6 COMMITTEE MEMBER UPDATES

Mr. Stuchbury and Miss Wood commented on the visits to the Buckinghamshire Learning Trust and the foster carer. They stated that both visits had been extremely informative and they expressed their gratitude to the hosts.

7 CABINET MEMBER UPDATES

7A CABINET MEMBER FOR CHILDREN'S SOCIAL CARE & LEARNING

The key issues raised by the Cabinet Member included:

- The Local Government Association peer review that had taken place
- The 'Courageous Conversations' process that had taken place with staff
- Availability of parking for social workers
- The Department for Education's visit on 24th November

SEE PAPERS/WEBCAST FOR CONTENT

7B CABINET MEMBER FOR EDUCATION & SKILLS

The key issues raised by the Cabinet Member included:

- An Ofsted inspection of adult learning is starting today
- Using fewer, larger providers for adult learning is being explored
- Free adult learning courses are being provided from 23rd November for 1 week
- Apprenticeships are being developed – there is support for 6 at a local primary school
- The number of good and outstanding schools moved from 81% to 87% in Buckinghamshire
- Un-validated performance in schools is the same as last year, broadly
- Special Education and Needs (SEN) reforms – there is a move from statements to Education, Health and Care (EHC) plans, alongside a new inspection regime
- The service is forecasting an overspend, which needs to be managed whilst minimising the impact on the front line

SEE PAPERS/WEBCAST FOR CONTENT

8 CHILDREN'S SERVICE IMPROVEMENT PROGRAMME UPDATE REPORT

Members raised the following issues with the Cabinet Member:

- The findings of the Local Government Association peer review
- The variable levels of improvement across the performance indicators since June last year when Ofsted arrived, including the associated costs and impact on outcomes
- Fluctuations in the numbers of cases being sent to MASH
- Recruitment and retention of social workers

The Cabinet Member in response to questioning highlighted the following points:

- The findings of the peer review were mixed
- Various factors played a role in the fluctuating performance indicators, including unpredictable demand and issues around recruitment and retention
- Social workers recruited from overseas are being given the help and support they need to adapt to working in the county

SEE PAPERS/WEBCAST FOR CONTENT

9 TO CONSIDER THE PROPOSALS IN THE FUTURE SHAPE CONSULTATION

The Service Director for Children's Social Care stated that the following principles underpinned the proposals:

- How joint commissioning with adult social care might work
- How the learning and children's social care aspects of the Business Unit can be more closely aligned.
- How to place the child at the centre of the Business Unit.

Members questioned the timing of the Future Shape programme given the current difficulties faced by the Business Unit.

SEE PAPERS/WEBCAST FOR CONTENT

10 CHILDREN'S INTERNET SAFETY INQUIRY PROGRESS UPDATE - 6 MONTHS ON

Members received the update from the Policy and Equalities Manager.

The following issues were raised:

- The connection between internet safety and the prevention of CSE
- The hosting of the Cyber Safety Conference in 2016, including the best choice of venue given costs
- Web-based cyber-safety content, including what it consisted of and its accessibility

The members then considered their assessment of progress on each of the recommendations as follows:

- **Recommendation 1:** Recommendation implemented to the satisfaction of the committee.
- **Recommendation 2:** Recommendation implemented to the satisfaction of the committee.
- **Recommendation 3:** Recommendation on track to be completed to the satisfaction of the committee.
- **Recommendation 4:** Recommendation on track to be completed to the satisfaction of the committee.
- **Recommendation 5:** Recommendation on track to be completed to the satisfaction of the committee.
- **Recommendation 6:** Recommendation on track to be completed to the satisfaction of the committee.
- **Recommendation 7:** Recommendation implemented to the satisfaction of the committee.

SEE PAPERS/WEBCAST FOR CONTENT

10A INTERNET SAFETY INQUIRY UPDATE DOCUMENT (COMPLETED)

11 CHILDREN'S SOCIAL SELECT COMMITTEE WORK PROGRAMME

It was agreed that the work programme should be discussed in detail at the informal session to be held that afternoon.

12 DATE OF NEXT MEETING

23rd February 2016.

13 EXCLUSION OF THE PRESS AND PUBLIC

Members agreed not to exclude the press and public for the following agenda item.

14 TO RECEIVE THE DRAFT REPORT OF THE PREVENTING CSE INQUIRY

Members discussed the draft report on child sexual exploitation (CSE).

The Committee resolved:

- To agree the Inquiry report and recommendations as a report of the Children's Social Care and learning Select Committee; and for the report to go forward to the Safeguarding Board and Cabinet

The report and its recommendations were to be presented for response to the Children Safeguarding Board and Cabinet.

SEE PAPERS/WEBCAST FOR CONTENT

CHAIRMAN

Buckinghamshire County Council

Select Committee

Children's Social Care and Learning Select Committee

Report to the Children's Social Care and Learning Select Committee

Title:	Prevent Agenda
Committee date:	Tuesday 23 February 2016
Author:	David Johnston, Managing Director, Children's Social Care & Learning Business Unit
Contact officer:	Yvette Thomas 01296 382461 ythomas@buckscc.gov.uk
Cabinet Member sign-off:	Lin Hazell, Cabinet Member for Children's Services

Purpose of Agenda Item

This report is intended to inform the Select Committee of the new Duty on public authorities including schools with regard to Prevent and an overview of the work BCC is currently doing to support schools.

Background

1. In 2011, the Coalition Government published its **Prevent Strategy;** one of the four elements of its overall strategy on counter terrorism and the only element which operates in the pre criminal space i.e. before an illegal act has been committed.

2. The Prevent Strategy aims to prevent people from becoming terrorists or supporting terrorism. It sets out three objectives around **ideology, individuals and institutions**:

   Objective 1: Respond to the ideological challenge of terrorism and the threat we face from those who promote it.
   Objective 2: Prevent people from being drawn into terrorism and ensure that they are given advice and support
   Objective 3: Work with sectors and institutions where there are risks of radicalisation

3. The **Counter Terrorism & Security Act 2015,** became law in February 2015 and:

- Gives the police the power to seize the passports of people suspected of being involved in terrorism;
- Introduces exclusion orders to prevent people from returning to the UK for up to two years unless the Home Secretary issues a permit to return
- Expands measures that can be included in terrorism prevention and investigation measures orders
- Requires communication service providers to retain data to allow the identification of the IP address an individual is using
- Gives the Home Secretary powers to require airlines to provide information on passengers and crews on flights
- Makes it an offence for an insurer in the UK to make ransom payments

4. It also introduces a **Prevent Duty (**enacted on 1 July 2015) which states that the prescribed bodies, in the exercise of their duties:

> "...*must have due regard to the need to prevent people from being drawn into terrorism*"

5. In summary, the Duty applies to:

- Local authorities
- Other agencies working with vulnerable adults, children and young people where the work is being discharged on behalf of a local authority
- NHS Trusts and NHS Foundation Trusts
- Higher & Further Education
- Schools
- Prison and probation
- The Police

6. There are two key elements to meeting the Prevent Duty:

- An assessment of the risk that goes beyond the Counter Terrorism Local Profiles (CTLP) produced by the Police so that there is demonstrable engagement with partners and those to whom the Duty applies. Prevent action plans will need to be developed to address any risks identified for an area and will, naturally, vary depending on whether or not an area is deemed a Prevent priority.

- The establishment of a Channel Panel so that any individuals of potential concern can be referred for appropriate interventions. There is an expectation that local authorities will incorporate the duty into existing policies and procedures, so it becomes part of the day-to-day work of the authority, such as the need to ensure that there are clear and robust safeguarding policies to identify children (or vulnerable adults) at risk of being drawn into terrorism.

7. Those in leadership positions are expected to:

    - Establish or use existing mechanisms for understanding the risk of radicalisation
    - Ensure staff understand the risk and build the capabilities to deal with it
    - Communicate and promote the importance of the duty
    - Ensure staff implement the duty effectively

8. There is an expectation that local authorities will incorporate the duty into existing policies and procedures, so it becomes part of the day-to-day work of the authority, such as the need to ensure that there are clear and robust safeguarding policies to identify children (or vulnerable adults) at risk of being drawn into terrorism.

9. All specified authorities subject to the duty will need to ensure they:

    - Provide appropriate training for staff involved in the implementation of this duty, including frontline staff who will need to understand what radicalisation means, why people may be vulnerable to it, how to spot the signs and how to report a potential referral to the **Channel Panel**;

    - Do not provide a platform for extremists through allowing them to hire publicly-owned venues or access public resources to disseminate extremist views (including through IT equipment);

    - Do not work with organisations who are engaged in any extremist activity or espouse extremist views; and

    - Maintain appropriate records to show compliance with their responsibilities and provide reports when requested; and

    - Have effective information sharing procedures in place that are proportionate and comply with the Data Protection Act 1998.

Summary

10. The information provided represents the work undertaken by officers at BCC as well as the Prevent Co-ordinator at Wycombe District Council, and the Prevent Officers from Thames Valley Police insofar as it relates to work with schools.

11. Including the independent sector, there are currently 269 educational establishments in Buckinghamshire. There has been a partnership approach to working with schools on raising awareness about the Prevent Duty.

Briefings to Schools

12. **County wide briefing sessions** held in January 2015 briefed Chairs of Governors and Headteachers on the duty and the support they could expect including:

Policy Support from BCC

13. The DfE have advised schools not to create a separate policy with regards to Prevent but to adapt relevant current polices to include Prevent. As a result

(i) The Safeguarding in Education Adviser has adapted the Safeguarding Model Policy to include radicalisation and extremism statements. The officer has also included Prevent in the audit tools related to Safeguarding.

(ii) The Policy and Equalities Manager has adapted the Model Policy on Equalities and Cohesion to include radicalisation and extremism statements as well as British Values

Training including Workshop to Raise Awareness of Prevent (WRAP)

14. **WRAP** is prescribed training for all frontline staff and was developed in partnership by the Police and the Home Office. It has a range of case studies which means it can be adapted depending on the audience and whether the focus is on adults or children and young people.

WRAP Training to Schools and Early Years Settings

15. The WRAP product takes up to 1.5 hours to run and is delivered as a standalone session and has also been incorporated as a component of other activities such as Designated Safeguarding Leads (DSL) training, or through the County Council's area based termly schools' liaison group meetings for school leaders

16. According to the data gathered up to December 2015 over a third of schools have received WRAP training. This is the first monitoring and review of the work that has been undertaken since the Duty came into effect. The findings reflect that a responsive approach to schools requesting support has developed as opposed to a systematic and proactive approach based on agreed priorities. A refocussing of this engagement will be addressed through the development of a county wide training strategy, which will include schools.

17. However, given the increased bookings for training in January and February, officers anticipate a significant increase in the number of schools that have undertaken training when the data is reviewed again at the end of quarter.

18. Wycombe District Council, as a Prevent priority area, is separately funded and was able to commission **bespoke training for students** attending schools in the Wycombe area (on critical thinking which challenges stereotypes and prejudice.

19. In order to promote community cohesion schools across the county were invited by the County Council to participate again in the **School Linking Network (SLN) for Primary Schools**. This provides the opportunity to develop school links with schools in different contexts to improve relations between pupils who would opportunities to engage with peers from different backgrounds. To date over 64 schools have formed links across Bucks.

20. The County Council also repeated its **SLN Model United Nations for Secondary Schools).** In separate events over 100 Year 9 and Year 12 students worked in teams of 3 with pupils from different schools over a 4/6 month period and then attend a role play event to debate a relevant topic. This year 13 Secondary Schools will debate in April Freedom of Movement in a Model General Assembly debate. 21Schools have the opportunity to attend **British Values Training** with the Bucks Learning Trust and on the 22nd February a Conference on British Values was held with attendance from over 60 school leaders and teaching staff

. 21. School **Governors** have the opportunity to attend either:

(a) Whole Governing Body training on Prevent
(b) County wide training

22**.** Children's Social Care and Learning Business Unit Staff
An on-going training schedule is available for all staff in CSC&L to be WRAP trained

Spotting the Signs of On-line Radicalisation

23. The County and three of the District Councils have pooled their Prevent Duty funding from the Home Office and, as a result, have been able to offer all schools the opportunity to have a staff member trained in **on line safety** with regard to radicalisation. The resources, developed by the University of Kent, will allow both teachers and students to have a clearer understanding of the dangers of radicalisation and the grooming that takes place on-line and gives the school a year's free access to the on line resources.

Key issues

24. It is important that all schools and early years settings receive training on Prevent in order to part meet their duty to show due regard. Better coordination of and engagement locally with the school based trainers should help to ensure they are able to maintain their accreditation as a WRAP trainer and enable the training to be delivered across schools at a much quicker pace.

Work is underway to have a webpage developed so that schools can have all the information including teaching resources in one place, including "Educate Against

Hate" (resources launched in January 2016 by the Education Secretary, Nicky Morgan).

Resource implications

25. There has been a small contribution to the County Council, Aylesbury and Chiltern and South Bucks District Councils of £10K each as one off funding to meet the Prevent Duty. Wycombe District Council, as a Prevent priority area, receives funding to employ a Prevent Coordinator. By and large much of the work done at County level has been absorbed by officers in to their current roles. This has led to capacity issues which we are trying to resolve.

Next steps

26. To assist in the development of the countywide training strategy so that schools based needs are reflected (including defining levels of engagement)

To set targets to increase the number of schools based individuals accredited to deliver WRAP

To monitor and review the delivery of WRAP across schools

To coordinate and have ongoing engagement with the WRAP trainers in the county

Buckinghamshire County Council

Select Committee

Children's Social Care and Learning Select Committee

Report to the Children's Social Care and Learning Select Committee

Title:	Development of the Children's Social Care & Learning Business Unit under the Future Shape Programme
Committee date:	Tuesday 23 February 2016
Author:	David Johnston
Contact officer:	Claire Hawkes, Business Manager ext 7306 chawkes@buckscc.gov.uk
Cabinet Member sign-off:	Lin Hazell

Purpose of Agenda Item

Information - The committee requested an update on how the Children's Social Care and Learning (CSC&L) Business Unit were developing under Future Shape programme

1. Background

The CSC&L Business Unit have been under intense scrutiny since its Ofsted inspection in June 2014. There has been significant scrutiny and challenge: Red Quadrant undertaking a diagnostic of the critical issues and offering challenge and support, and writing monthly reports to DfE; OFSTED audits, LGA Peer review in October; LGA interviews looking at DMA; DfE visit in November to review the improvement notice; which resulted in 6 days auditing in January. In addition there have been several multi agency improvement events, monthly Improvement Board with an independent chair. There has also been regular internal challenge: Several 'deep dives' from One Council Board to support future thinking and shaping of services, staff events such as courageous conversations, practitioner's board, leadership collaboration events, Cabinet, LAG, Buckinghamshire Safeguarding Children's Board and Select Committee reviews.

These interventions have meant most aspects of social care have been subject to rigorous review. This allows us to reflect not only on our improvements but also evaluate where we

are on our improvement journey and ensure we amend out focus on continuous improvement.

Future shape went live on the 1st April 2015; we have been developing as a business unit over the last 10 months. We are focusing on our statutory duties to safeguard and support children but also developing our systems and procedures into a more business focused model. Whilst we are not in a position to charge for the majority of our interventions due to the statutory nature of our intervention, we have been ensuring that we spend public money judiciously, and explore alternative delivery models which improves interventions for children

2. Vision and key priorities

The business plan highlights how the service delivers the Council's strategic priorities:

- Safeguarding Our Vulnerable Children and Families
- Creating Opportunities & Building Self-Reliance
- Keeping Buckinghamshire Thriving & Attractive

Safeguarding and protecting our vulnerable children and supporting all children and young people to reach their full potential through learning and building resilience is an essential focal point for the Local Authority. The work of unit is critical and at times very challenging. Teams provide meaningful intervention and appropriate assessment in order to protect and support children. A significant area of priority is the continued focus on the recommended actions following the inadequate inspection of our safeguarding services. Developed in partnership with our stakeholders, the Improvement Board regularly monitors and challenges progress.

With increasing referrals and predication patterns showing need is not likely to cease (this increase brings us in line with other council's), it is essential that time and energy is given to protecting our most vulnerable children. Along with the statutory powers of investigating and supporting children in need / children in need of protection/children requiring care, responding to and preventing child sexual exploration (CSE) and radicalisation is a high priority for the business unit.

Our education system is highly regarded with the majority of our performance indicators above national average. We remain focused on championing education and building relationships with education providers to make sure that necessary change and improvements happen and all Buckinghamshire children and young people have the opportunity to reach their full potential. A key priority area is to continue improving outcomes for vulnerable children and those at risk of underachievement. We have a duty to ensure there are enough school places (based on DfE statutory guidance), having diversity in provision to enable parents to have a choice as far as practicable. Pupil projections are highlighting larger than average rises and there are complexities such as availability of

funding, land, transport and trends i.e. migration away from independent schools. As such another the key priority area is the strategic planning for school places and seeking influence in order for pupils to be places in local good schools/ provision.

3. Customers

Unlike other Business Units, with social care statutory powers most of our customers are not actively looking to engage with us. We are intervening in family's lives at a very critical time; often they are in crisis, angry, may have drug or alcohol dependencies, mental health issues. Sometimes families can be caught in a cycle of deprivation where lives have spiralled out of control and abuse has been prevalent for many years, in some cases generations.

There is no quick fix solution, lives change through determined, motived staff that work patiently and slowly with a family at their pace, to protect children and to turn lives around and have sustained positive improvement's. Some of our families can be very affluent and their intervention by social care is judgemental, rebutting the services attempts at support. Equally, some families will recognise there is an issue and engage well with us willingly

Children of all ages present a wide variety of needs and we need to focus our interventions to best support their well-being throughout their life. Our staff deal with a myriad of emotions not only from the child, whose is there first priority, but also the family. With over 400 referrals a month, staff are skilled at working at pace; with so many variables they do not know what will happen from one day to the next. The business needs to be planned with an ability to adapt quickly and responsibly.

Other customers are commissioned services who deliver statutory duties on our behalf. Our role often changes where we need to work in partnership in order to gain trust, influence and change to the market place i.e. school places. This requires skilled officers to ensure providers are not only engaging but also challenged to keep improvement and delivering excellent outcomes for our children.

Majority of our work is dependent upon good collaborative working, both at a strategic and operational level. With a multi-agency approach (police, health, foster carers / agencies, education providers, childcare providers etc), it requires skilled, patient working that utilises all resources available in order to achieve a collective vision. In order to prevent children and their families requiring statutory interventions, work over the last 6 months has also focussed on the development of early help panels; to ensure a coordinated response to children and their families. Over 500 families have been considered and this approach has ensure that the right service has been delivered to children and their families with only 50% of lead through our own in- house service (Family Resilience Service)

Our staff (and staff within other business units) are also essential customers and we work to ensure they are motivated (the recent various interventions can often leave staff exhausted

and demoralised, this is on top of very stressful work pressures), have regular opportunities to engage with managers and members through staff feedback sessions, work shadowing etc. and encouraged to be innovate coming forward with ideas for improvement. We have also been working with the Innovations Team to develop opportunities following staff ideas. The social work academy which was launched last year in collaboration with Bucks New University has offered continual leaning and a pipeline for future social workers

We have a responsibility for monitoring complaints, as a business unit we regularly assess numbers of complaints and compliments (the nature of some interventions means there will always be complaints about the service). The compliments are recorded centrally and shared throughout the service, it is important that teams receive recognition for their work as well as learning from best practice. The response rates and themes to complaints are monitored centrally, performance is challenged where necessary and training is given to enhance services. Work has also been done on standardisation and being clear about expectations (both on our staff and for those receiving services).

4. Business Improvement

Demand for services is increasing, the number of rising social care and SEND referrals has knock on effects into other areas of the service. There is increase pressure to find suitable accommodation which meets the child's needs, with a lack of placements nationally it means costs for children's care is rising, putting greater pressures on budgets. There is an increased pressure on SEND which results in further cost pressures for home to school transport. There is an increased demand for school places due to increase in birth rates and inward migration, prediction for growth in pupil numbers is concerning. Shortage of key workers places pressures on budgets and could influence outcomes for children.

With demand pressures on services and there is a constant challenge to provide value for money services that have the right intervention and the right time in the best interests of the child. As a unit we are focusing (and will continue to focus on) on bringing the unit together. Traditionally the unit has been separated into Social Care, Education and Commissioning with, at times, a silo mentality. We are generating a new way of thinking that focuses more holistically on the child. The same children often are seen in various parts of the service, we need to be more joined up in our approach to working with these children and families. This has involved staff training, more communication across the service, more engagement and sharing of best practice.

Being more commercially aware is always at the forefront of service development decisions. With increasing pressures on resources, there is a need to think differently and approach work with a different perspective. With the dramatic rise in the number of Buckinghamshire children in care, the service has increased the use of external foster placements and residential care with significant cost implications (a residential placement costs £4,000 a week on average). The resource panel has been focusing on challenging

need and looking for best value whilst meeting the child's needs. Approximately 52% of looked after children are placed outside county borders; this is the highest in the Country. We are exploring how we can develop more market opportunity in placing children including development of fostering services. Changes to the market place have also taken place within Adult Learning, exploring novation of services.

There are various digital platforms used across the units as the work is so diverse. Plans are developing to critique all use of platforms and working with customer digitals board to maximise our developments. The unit is also challenging teams to be paperless, something that has already saved the council money. Officers have now got used to taking lap tops to meetings rather than having papers (which also makes the service more resilient in terms of business continuity planning), emailing forms rather than posting, scanning rather than keeping documents. Changes to mobile phones and apps help staff (and provide a more responsive service) when off site. Teams will be challenged further and ideas monitored.

The council has a lot of data and we are getting better at recognising where the data exists, where gaps are, utilising reports more by having more insight with data analysis. The unit is working with HQ Business Intelligence Team to develop a tool to help social workers and managements in their decision making and demand management. Using predicative modelling techniques, the tool can predict the likelihood of children requiring a social care intervention. The model uses a variety of factors we know about children we have been in contact with, including key issues for families, demographics and information about what services they are currently or have previously accessed to predict the likelihood of the child needed different levels of intervention in the future. For example, the model calculates a likelihood score of a child becoming looked after or becoming subject to a Child Protection Plan. This tool is about to be piloted with operational managers to support them in decision making, case management, supervision and prioritisation. It is hoped that this will provide insight into the relationships of key factors about children to support their professional judgement and also be used to manage demand and provide the right service at the right time to families to prevent the need for high level intervention

Summary

The service is working towards future shape and has developed significantly over the last year. There will be more changes throughout the year as practice develops, more sophisticated data predications are generated and further improvements within business functions. Teams have been working hard to continue with the day to day complexities of service demands whilst under intense scrutiny, thinking more broadly in respect to asset and resource management including accessing match funding or seeking alternative funding or delivery vehicles where appropriate.

Buckinghamshire County Council

Select Committee

Children's Social Care and Learning Select Committee

Report to the Children's Social Care and Learning Select Committee

Title:	Children's Peer Review and Revised Improvement Plan
Committee date:	Tuesday 23 February 2016
Author:	Cabinet Member for Children's Services
Contact officer:	Hannah Dell 01296382602
Cabinet Member sign-off:	Lin Hazell, Cabinet Member for Children's Services

Summary

In October 2015, as part of the Improvement Programme in Children's Services, the County Council asked the LGA to undertake a Peer Review of Children's Safeguarding Services in Buckinghamshire to measure progress since the Ofsted inspection. Overall the team were impressed with the hard work and dedication from all partners to work together and improve services for children and young people in Buckinghamshire. However, whilst they identified a number of strengths and improvements made since the Ofsted inspection, as expected, they also identified a number of areas for further improvement. The emerging themes were around pace of change and the need to ensure consistency of good social work practice. A copy of the Peer Review letter is attached for information.

In November 2015, the DfE visited to review progress and commissioned some further case file auditing to be undertaken in January 2016 before making a recommendation to the Minister on any changes to the level of intervention in Buckinghamshire. The Auditors were onsite for 5 days and reviewed over 90 children's records. They submitted their report to the DfE and the DfE shared it with the County Council at the end of January. The Auditors concluded 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". The Minister is now considering the findings of the audit, and other evidence (including from the DfE review in November) in making a decision about the Department's intervention and we expect to receive formal notification in the next week or so. A copy of the Auditors' report is attached for information.

The decision was taken to refresh the Improvement Plan in light of all of the recent scrutiny to ensure that it is focussed on the areas of work that require further improvement. The refreshed plan has been developed in partnership with all key stakeholders and focuses on 4 key priorities for the next 12 months (January to December 2016). The priority areas are:

- The leadership, culture, values and behaviour of the partnership ensure good outcomes for children and young people
- Best practice for children is consistent in all areas of frontline services
- Resources support good practice and improved outcomes for children and young people
- Self-knowledge, informed by listening to and acting on the voice of children and young people, drives improvements

The plan will be delivered through a variety of project boards and task and finish groups. Each priority area will have a number of project plans attached to it to ensure the necessary improvements and that the pace of change is maintained. The plan was considered by the Improvement Board on 8th February, and following a few amendments it will be published on the Council's Improvement Programme webpage and presented to Cabinet for information.

David Johnston
Managing Director
Children's Social Care and Learning
Buckinghamshire County Council
5-7 Walton Street
Aylesbury
Bucks
HP20 1UA

October 2015

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.
How we are ensuring hearing the voice of the child and impact	**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
Programme Manager (Children's Services)
Local Government Association

Appendix One: Case Records Review

Appendix Two: Information Health check

Appendix Three: Flipcharts from prioritisation workshop

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.

John Hyder-Wilson, PhD, MA, BSc, CQSW

Suzi Ingram, MA, BA, DipSW

INGSON Ltd: appointed Department for Education Improvement Advisors

22 January 2016

Principal Sources

Working Together to Safeguard Children 2015: HMSO London