Children's & Education Select Committee agenda

Date: Thursday 4 March 2021

Time: 2.00 pm

Venue: Virtual Meeting via MS Teams

Membership:

S Adoh, D Barnes, M Collins, E Culverhouse, D Dhillon (Chairman), B Foster, A Hussain, N Hussain, S Jarvis, D Johncock, R Jones, P Kelly, R Stuchbury, P Turner, J Ward (Vice-Chairman) and M Shaw

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Agenda Item		Time	Page No
1	**Apologies for absence**		
2	**Declarations of interest**		
3	**Minutes** To confirm the minutes of the meeting held on 7th January 2021 as a correct record.		5 - 10

4 Public Questions

5 Support for Care Leavers **14:05**

The Committee will receive a verbal update on the support that the Council provides to Care Leavers, including potential projects being explored with colleagues in Housing.

Contributors:
Mr Mark Shaw, Cabinet Member for Children's Services
Mr Tolis Vouyioukas, Corporate Director for Children's Services
Mr Richard Nash, Service Director, Children's Social Care

6 Ofsted Self-Assessment Presentation **14:40** **11 - 22**

This is an opportunity for the Committee to discuss and ask questions on the Council's self-assessment presentation that was prepared for the recent Ofsted monitoring visit, which was particularly focussed on the Covid-19 response.

Contributors:
Cllr Mark Shaw, Cabinet Member for Children's Services
Mr Tolis Vouyioukas, Corporate Director for Children's Services
Mr Richard Nash, Service Director, Children's Social Care

7 Update on Children's Services Improvement Plan **15:05** **23 - 36**

The Committee will receive an update on progress with the Children's Services Improvement Plan, which was reported to Cabinet on 16th February 2021.

Contributors:
Cllr Mark Shaw, Cabinet Member for Children's Services
Mr Tolis Vouyioukas, Corporate Director for Children's Services
Mr Richard Nash, Service Director, Children's Social Care

8 Date of next meeting

Due to the Elections taking place on 6th May 2021, this is the last Select Committee meeting before the new Council. Dates of future meetings to be advised.

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: Kelly Sutherland on 01296 383602, email democracy@buckinghamshire.gov.uk.

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Buckinghamshire Council

Children's & Education Select Committee

Minutes

MINUTES OF THE MEETING OF THE CHILDREN'S & EDUCATION SELECT COMMITTEE HELD ON THURSDAY 7 JANUARY 2021 IN VIA MS TEAMS, COMMENCING AT 2.00 PM AND CONCLUDING AT 3.42 PM

MEMBERS PRESENT

D Barnes, E Culverhouse, D Dhillon, A Hussain, N Hussain, D Johncock, P Kelly, R Stuchbury, J Ward and T Green

OTHERS IN ATTENDANCE

C Pease, M Skoyles, Dr J Clacey, A Cranmer, Mr S James, T Vouyioukas, Dr E Rowsell, F Habgood, Mrs D Rutley, S Taylor and K Sutherland

Agenda Item

1 APOLOGIES FOR ABSENCE

Apologies were received from Cllr Julie Ward, Cllr Shade Adoh, Cllr Mike Collins, Cllr Robert Jones and Cllr Paul Turner. Sir Francis Habgood joined the meeting at approximately 3.00 pm.

2 DECLARATIONS OF INTEREST

Cllr Dominic Barnes declared that his wife worked for a grammar school in Buckinghamshire.

3 MINUTES

Cllr Dev Dhillon, the Chairman, advised that the actions had been discharged apart from the action under item 7, Educational Standards; the Chairman advised that the number of children in elective home education was 738.

Cllr Johncock referred to item 7, Educational Standards, page 10 of the agenda pack, which stated that information on the high number of exclusion rates for black and minority ethnic (BAME) children and how it would be addressed would be included in the next report to the Select Committee; Mr Simon James, Service Director, Education, confirmed the information would be included in the next report but agreed to circulate the it separately.

ACTION: Mr James

Cllr Johncock also referred to item 8, Work Programme on page 12, which stated that a sub-group to discuss the recruitment of social workers would be set up. The Chairman advised that the Select Committee members should have received an email before Christmas advising that,

due to Covid restrictions and officer workload, it had been decided to postpone this work until there was increased capacity.

Cllr Stuchbury requested an update on the number of children who required a laptop. Cllr Stuchbury had raised the query during the last meeting, but it had not been included in the minutes. Mr Vouyioukas, Corporate Director, Children's Services, stated that over 850 laptops were distributed to disadvantaged pupils during the first two lockdowns; there was now the impact of the third lockdown and the issue on the Department for Education (DfE) website for ordering laptops needed to be resolved. Mr Vouyioukas advised that he continued to discuss the issue with the DfE and offered to discuss the matter with Cllr Stuchbury outside of the meeting.

ACTION: Mr Vouyioukas

Mr Mark Skoyles referred to item 6, Family Support Service, One Year On, the first bullet point on page 7, and requested clarity on the information provided. Mr James confirmed that there were 16 Family Support Service centres and agreed to email Mr Skoyles regarding the number of youth centres and their management arrangements.

ACTION: Mr James

RESOLVED: The minutes of the meeting held on 5 November 2020 were AGREED as an accurate record.

4 PUBLIC QUESTIONS

There were no public questions.

5 CHAIRMAN'S UPDATE

The Chairman requested that members of the Select Committee raise any further questions directly with the relevant officer.

6 CHILDREN'S MENTAL HEALTH

The Chairman welcomed Dr Eleanor Rowsell, Head of Psychological Therapies, Bucks Child and Adolescent Mental Health Services (CAMHS); Dr Joe Clacey, Consultant Child and Adolescent Psychiatrist/Medical Lead for Bucks CAMHS and Ms Debra Rutley, Executive Headteacher at Aspire Schools, to the meeting to advise on the mental health impact of Covid-19 and what was being provided to support children and families. Mr James introduced the report which outlined the provision from CAMHS and the schools' system; Mr James referred to the data in point 7 of the report and advised that the most up to date information would be provided after the meeting.

ACTION: Mr James

Dr Rowsell explained that CAMHS was an NHS commissioned service, delivered by Oxford Health; CAMHS commissioned online services and also worked in partnership with Barnardo's. Mental Health Support teams had been developed and several structured clinical pathways were in place along with an outreach service. Nationally, there had been a 51% reduction in CAMHS referrals in April 2020, compared to April 2019, which was probably related to the closure of schools; however, by September 2020 there was a marked recovery. The national benchmarking exercise normally covered the whole year but in October 2020 the rates were already 22% higher than in 2019 comparable levels. The chart in point 6 shows graphically, that there were large fluctuations which related to school terms; there was usually a significant rise in October/November. The increased referrals locally since August 2020 had mirrored national figures and had continued to rise.

There was an increase in referrals for the mental health support teams which was a new

national project. It was part of the natural service development but demonstrated that there had been an increase in demand for the mild pathways. There had been a 42% increase in the crisis assessment area of the service and there had been a 32% increase in eating disorder referrals which was of concern nationally. The number of paediatric assessments and admissions had risen by 50% compared to the same period last year and it was a concern that young people presenting to the service were so low weight that they needed a paediatric assessment and admission. There had also been an increase in Obsessive Compulsive Disorder referrals and a slight increase in drug and alcohol and bi-polar disorder. CAMHS had looked at the impact of other pandemics and had anticipated higher levels of anxiety and depression; however, post-traumatic stress disorder (PTSD) had not been noted at this stage.

Dr Joe Clacey explained that, in addition to his role as the Consultant Child and Adolescent Psychiatrist/Medical Lead for Bucks CAMHS, he also led the Crisis and Outreach Service and one of the significant concerns was an increase in self-harm presentations. There had been a 42% increase in the relevant time period; young people were also presenting with increased amounts of reported thoughts of suicide. There had not been an increase in very severe outcomes i.e. those suffering severe long-term harm, completed suicide or admissions to psychiatric inpatient care. Increased referrals had led to considerable pressures throughout the wider system. Self-harm referrals also involved colleagues in social care and the multi-agency safeguarding hub (MASH) and work had been undertaken, due to Covid-19, to allow information sharing and improved links. Staffing had been prioritised/increased in acute pathways, but this removed staff from other areas. It was unclear what aspects of the lockdown had caused the increase; it was likely to be multi-factorial and it was clear that the service would not see a reduction in demand soon.

Dr Rowsell summarised that there was a flexed workforce to cover the priorities. There had been a very rapid move to digital services and a large proportion of work was carried out online. There was a national issue in recruitment and the Eating Disorder team had only been able to recruit one extra member of staff. The Buckinghamshire Mental Health Covid-19 Strategic Response Group, chaired by Oxford Health and Public Health, had produced an action plan focussed on vulnerable groups; there was also a specific action plan for children and young people which included a Children and Young People Suicide Prevention Group.

Debra Rutley, Executive Head of Aspire Schools, explained that Aspire Schools looked after the children who sat outside mainstream school; there were four school sites with two specific mental health school sites, one in the north and one in the south of Buckinghamshire, referred by schools and supported by CAMHS. A home tuition service was also offered for primary to year 11 students who were too unwell to attend school, along with a behaviour support service which worked with all the secondary schools in Buckinghamshire to provide a mentoring service for students. There was also a teaching school which provided training and support for teachers and school leaders.

Aspire became involved in a Wellbeing Project which was developed during lockdown for lockdown; it had gone ahead as planned and was combined with the DfE programme to produce a larger offer. There was a training package for all schools and school leaders, specific coaching and one to one support for school leaders and staff and specific training for teaching staff. Bespoke wellbeing support, in relation to Covid-19, was also available within primary and secondary schools for children and young people. Generally, it was a much broader offer than what was available across the rest of the country. To date, 90% of schools had undertaken the training and 250 additional school staff had received specific enhanced training e.g. on the impact of Covid-19 on mental health. 20 head teachers were receiving coaching support and 50 teachers were being offered coaching, supervision and mentoring support. 13 schools were

receiving specific additional support for young people of concern. The aim was to provide a safe environment for children; parents would be encouraged to bring their children back to school. The Wellbeing Project had resulted in the teachers and leaders feeling more knowledgeable and supported along with the children and families.

The following key points were raised in discussion:

- A committee member referred to the table under paragraph 7 of the report and asked for the actual number of cases being dealt with in order to understand the demand on the service. Dr Rowsell advised that the chart in paragraph 6 showed that there were 1,182 referrals in November 2020; the average was 716 per month (during 2018-2021). There were 22 referrals to the Eating Disorder Service during November; the average over two years had been nine. The Mental Health Support Team had received 60 referrals; the average was 35.
- In response to being asked what neuro developmental covered; Dr Rowsell explained that there were two neuro developmental pathways, an existing one in Oxford Health CAMHS which saw young people with an autistic spectrum disorder or attention deficit hyperactivity disorder (ADHD) and a neuro collaborative pathway, which was relatively new, and was a multi-agency pathway. Dr Rowsell stressed that there was a huge demand on neuro development services.
- A Member highlighted that the Council was considering a £2.7m reduction in Children's Services and a £2.9m reduction in Community Services; and asked which elements of the service were funded by the Council. Mr James clarified that Clinical Commissioning Group (CCG) and the NHS funded CAMHS; it was not a council funded service.
- In response to being asked how self-referrals were defined; Dr Rowsell stated that she encouraged self-referrals as it was preferable to obtain the information from the individual themselves , there was an open door system via the single point of contact and anyone was able to ring for a consultation which could become a self-referral, if appropriate. There was also an online referral form.
- Clarification was requested on the meaning of the conversion rate in the table in paragraph 7 on page 17. Dr Rowsell explained that national CAMHS service data was used to compare with what was carried out in Buckinghamshire. Buckinghamshire received more referrals than the national mean. The percentage of urgent referrals was only 3% in Buckinghamshire, nationally the figure was 12% which was good. Approximately 3,000 referrals were accepted which was higher than the national average. The conversation rate was 60% but the national conversion rate was 70%. However, because Buckinghamshire received such a high volume, the proportion accepted was lower and reflected the remodelled CAMHS service and the introduction of the single point of access.
- In response to being asked where a young person would be signposted to if they were not accepted into the CAMHS; Dr Rowsell explained that there were several options, depending on need, such as Kooth (an online service) or the Family Support Service.
- When asked what the main cause of the increase in the referrals for eating disorders was; Dr Rowsell explained it could be related to a number of things such as a change of routine, the limited contact with other systems such as GPs and schools, information on social media or a delay in seeking help due to Covid concerns.
- A member asked how the service was coping with the increase in suicidality. Dr Clacey advised there was a crisis team which operated 24/7 and staffing had been prioritised to ensure cover as it was a concern.
- The Chairman asked Ms Rutley if further training sessions were planned for headteachers and teaching staff. Ms Rutley confirmed it was an ongoing programme and would be run

until the end of the academic year. There was a website called 'Connecting Bucks'; all the training information was available along with signposting.

- A member of the Committee asked about waiting times. The waiting time was approximately one month. Dr Clacey added that there no such thing as a waiting list for the Crisis Team or those requiring an urgent assessment.
- When asked if the service was sufficiently resourced; Dr Rowsell explained that, unfortunately, it had been challenging to fill vacancies and they did not have all the resources to meet the increase in demand; there had not been an increase in funding and resources had been managed/re-directed.

The Chairman, on behalf of the Select Committee, thanked Dr Rowsell, Dr Clacey and Ms Rutley for their attendance, the excellent verbal updates and the report.

7 BUCKINGHAMSHIRE SAFEGUARDING PARTNERSHIP

The Chairman welcomed Sir Francis Habgood, Independent Chair of the Buckinghamshire Safeguarding Children's Partnership whose role was to ensure children and young people were safeguarded in Buckinghamshire by providing leadership, support, challenge and quality assurance. Sir Francis emphasised that he did not represent any single organisation; he represented the partnership and he also chaired the Safeguarding Adults' Board. It was the first time there had been an independent chair for both partnership/boards; it was a positive factor as there were similarities and crossover. Sharing a Chairman would prevent gaps and help provide a smooth transition from childhood to adulthood.

The report stated that there used to be a Children's Safeguarding Board, but it was changed from a board to a partnership in 2019. There were three statutory partners in the partnership; the Local Authority, the Police and the CCG who all had joint and equal responsibility. A key priority was to make sure all three partners took on the responsibility and to ensure a business plan was in place and an annual report was produced. An effective quality assurance framework needed to be in place and a key responsibility was learning and development which was embedded, and made available to statutory partners and other organisations, after a study of case reviews.

A small business unit covered both the children's safeguarding partnership and adults safeguarding board; the team supported the senior leaders who lead the sub-groups across children's and adults safeguarding areas. There were several partnership boards across Buckinghamshire; links between the boards were important and a new domestic abuse board would be set up from April 2021. Sir Francis stressed the need to have a robust process to ensure learning was captured from the case review recommendations. The final page of the report showed the aims/priorities for 2021; most of which had been completed. There was a new website and an online conference would be arranged.

The following key points were raised in discussion with Members:

- In response to whether councillors would be able to attend the forthcoming event on 21 January 2021; Sir Francis advised he would check availability and let the Chairman know.
- Clarification was requested on the point that there were no serious case reviews regarding 22 child deaths; Sir Francis explained that none of the child deaths were of a safeguarding concern; they were medically related.
- A member of the committee highlighted that there was a planned reduction in the Children's Services budget of £2.8m and asked if the Children's Safeguarding Partnership was partly funded by Children's Services; Sir Francis assured the Select Committee that all the funding partners would continue to provide the same level of funding. Mr

Vouyioukas added that the financial commitment from the Council would not be withdrawn from the Children's Safeguarding Partnership.

- Sir Francis confirmed that the Joint Protocol document referred to in paragraph 1.8 had been agreed but he was unsure if it had been published. It was agreed that Mr Vouyioukas would identify if the joint protocol document had been published and send to Mrs Sutherland for circulation.

Action: Mr Vouyioukas/Mrs Sutherland

- In response to being asked if it would be of benefit to merge the Adult Safeguarding Board and the Children's Safeguarding Partnership; Sir Francis advised that it had been discussed but it was not the right time for them to be combined in Buckinghamshire.
- The Chairman referred to the three-year business plan mentioned on page 40 and asked for details of the plan. Sir Francis stated that the plan had been published and the three key areas were the principle of making safeguarding personal (understanding the lived experiences of the child), learning and development for the statutory partners and practitioners and ensuring the business process framework was in place.
- In response to being asked how the return to home interviews were carried out and the difficulty for an abused young person to be open, Sir Francis explained that it was essential to understand the underlying cause of why someone had gone missing and an independent person allowed a more open conversation. Mr Nash advised that the return to home interview was not a one-time event; there was a statutory obligation to hold an interview within a timeframe and a follow-up interview would be held if necessary.
  Richard Nash, Service Director, Children's Social Care, chaired the exploitation sub-group which ensured the correct procedure was carried out when a child went missing.
- Following a question on how the partnership was involved with the Children's Services Improvement Plan; Mr Vouyioukas stated that the safeguarding partnership had no connection or involvement with improvement plan.

The Chairman thanked Sir Francis for the report and for attending the meeting.

RESOLVED: The Select Committee NOTED the progress made by the Buckinghamshire Safeguarding Children Partnership during the last year.

8 WORK PROGRAMME

It was agreed that the item "Support to Care Leavers", lead officer Mr Nash, would be presented at the meeting on 4 March 2021.

Cllr Stuchbury requested early sight on the effect of Covid-19 on children's education and the 11+ when it became available.

The Chairman thanked all the Children's Services officers, school staff, teachers and care workers on behalf of the committee for all their hard work.

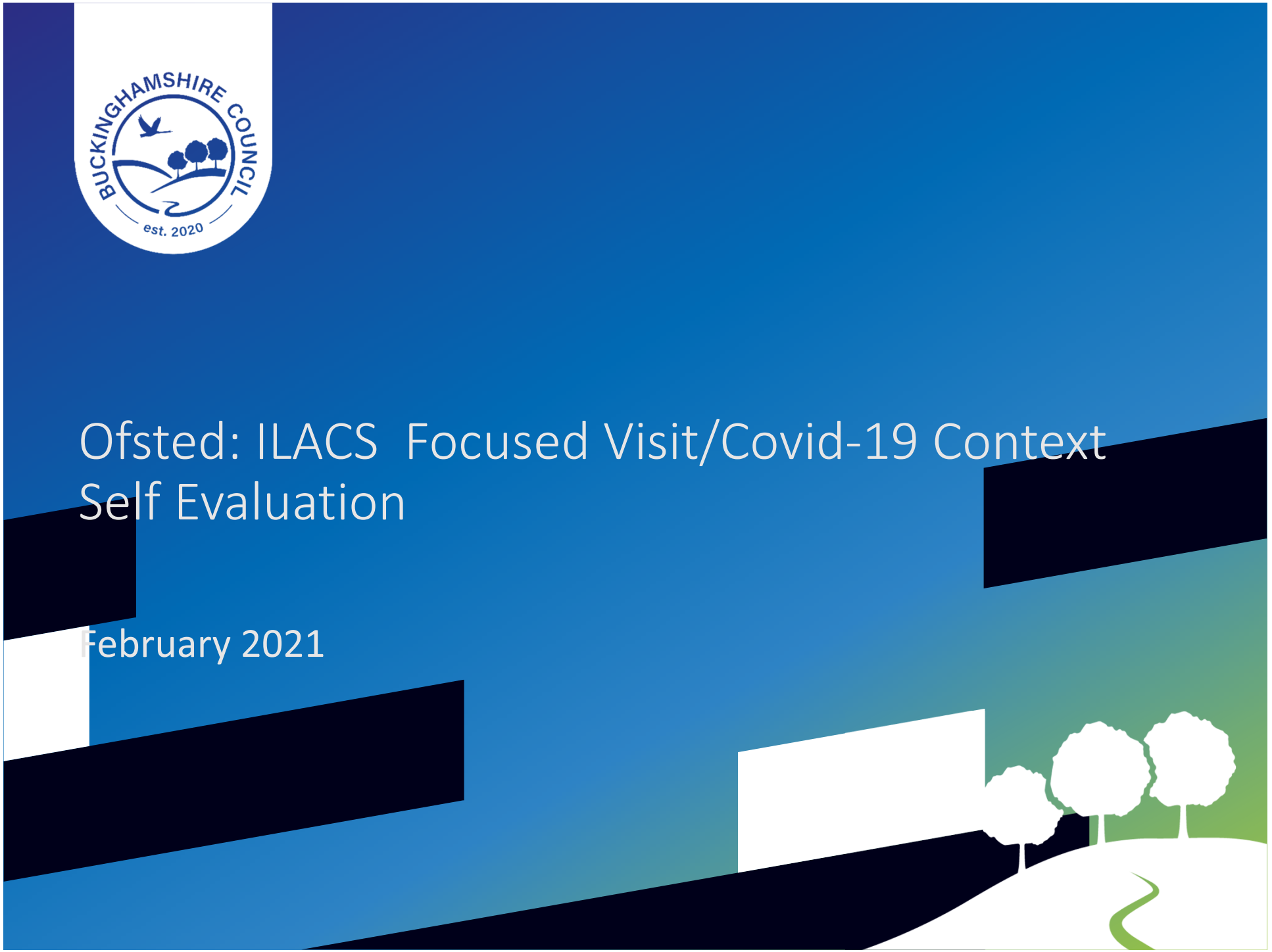
RESOLVED: The Children and Education Select Committee NOTED the work programme.

9 DATE OF NEXT MEETING

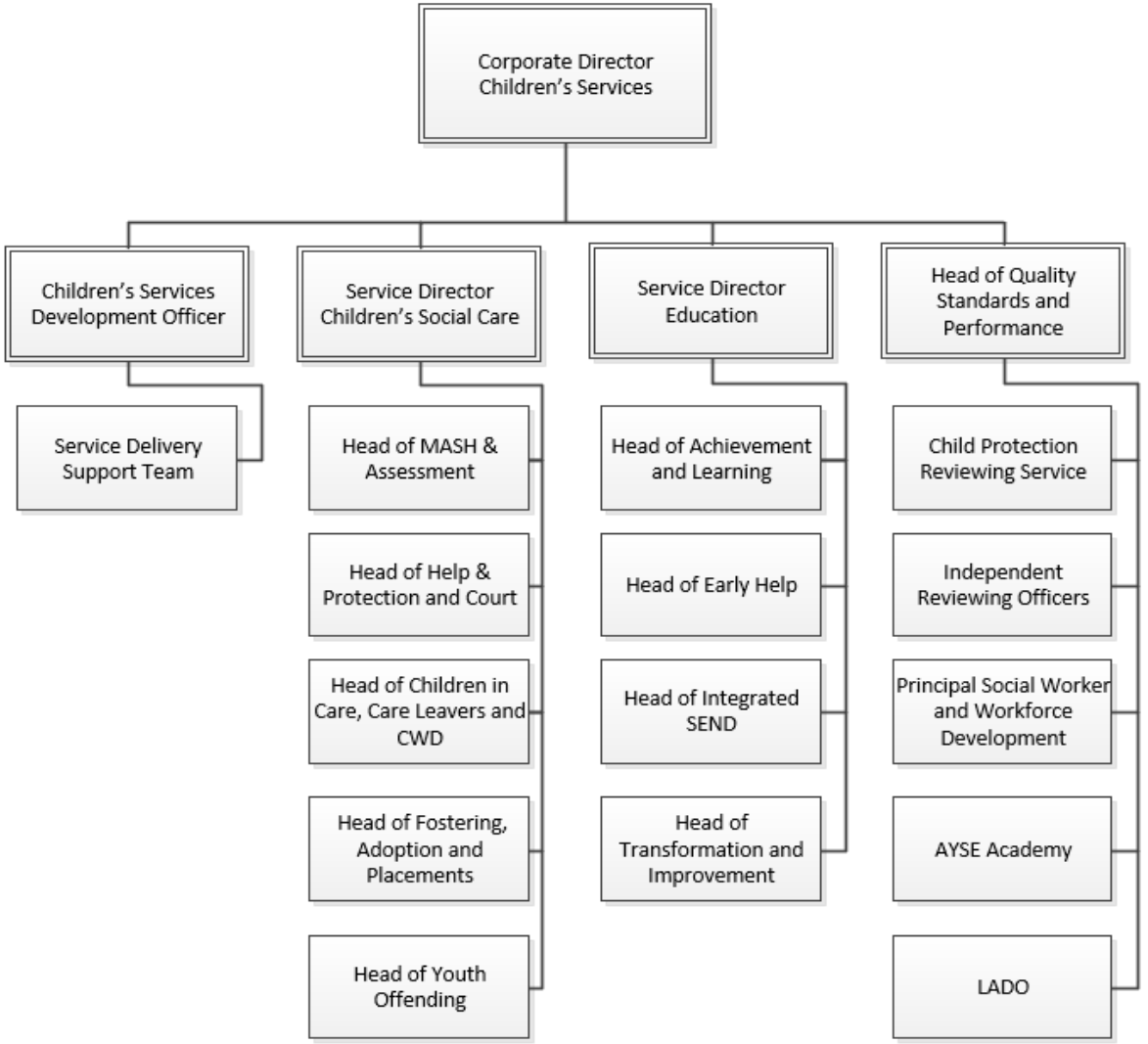
Thursday 4 March 2021 at 2.00 pm.

Ofsted: ILACS Focused Visit/Covid-19 Context Self Evaluation

February 2021



Children's Services Structure



COVID-19 Response (1)

1. It became clear during March 2020 that reducing the risk of infection and protecting the community as well as our staff was of primary importance. At that point in time, the entire service was being delivered remotely and the majority of social work activity was based on virtual interactions with children, young people and their families. Home visits took place only when agreed by the relevant Head of Service and these were triggered when there was no other way of being confident of the safety of children.

2. A number of key decisions and actions were immediately taken to mitigate risk and ensure that close management oversight was maintained. These included:

    a) The creation of a new case note type on our electronic recording system (LCS) so that all virtual contacts could be tracked and performance data reports run. This has allowed all virtual contacts to be isolated on the recording system and be audited.
    b) Heads of Service started daily touchdowns with their staff using Microsoft Teams. These daily meetings managed and controlled the move to a 100% remote service. This included discussions on how to achieve virtual statutory meetings, virtual visits, virtual assessments and the basis on which home visits would be conducted.
    c) A set of practice standards were created and issued to all staff highlighting the expectations in relation to a virtual visit, as well as the process for agreeing a home visit.
    d) A comprehensive audit and dip sampling process was set up so that the whole service including senior managers could have a clear understanding of the work of the service in the current high risk environment.
    e) Systems were put in place to ensure that all social workers had access to PPE in the event they were required to complete a home visit. The social worker had the final decision on whether they enter the family home, based upon responses received from the family at the 'doorstep'.

COVID-19 Response (2)

3. The decisions taken by the service in response to Covid-19 were put in place before any guidance from the Department for Education (DfE) was issued. The DCS and his senior team maintained close contact with the DfE and OFSTED colleagues via regular Microsoft Teams meetings. The service carefully explained all of the actions that had been taken in detail, as highlighted above. Our response to Covid-19 was supported and indeed confirmed that a number of other local authorities were about to take similar steps.

4. Our partnership with schools has not only been sustained throughout the pandemic but has been strengthened significantly. The DCS and his teams have been meeting at least twice a week to consider emerging themes and trends and solve problems. Issues resolved have included: lateral flow testing, access to laptops and re-opening of schools. These meetings have been pivotal to our collective response and have given us a very clear understanding of what is happening across our family of schools.

5. Supporting our staff to manage the demands of the work remains as always a high priority; however, there has been a greater need to check on the well-being of our front-line workers given the continued need to work remotely and deal with a high volume of difficult and disturbing case work. This has been supported by the corporate centre and staff survey results during the pandemic showed that 89% of our staff felt supported by the council.

6. Changes and increases in demand have put considerable pressure on front-line teams. There have been significant increases in the seriousness of incidents involving children and young people. As a result, the service has moved resources internally to support the MASH and the Assessment Teams. In addition, strong political and corporate support has released funds for an additional 21 social workers. Recruitment is underway with some successful appointments already made.

COVID-19 Response (3)

7. Physical visiting to children and young people has been maintained throughout. Visits are risked assessed and significant resource has been put into supporting, analysing and managing visits to vulnerable children and young people. This has resulted in strong performance and the maintenance of effective relationships with children, young people and their families.

8. The corporate, political and MP support has been critical to our success as a place to keep services going for children and young people across Buckinghamshire. The DCS and the corporate management team led by the CE have been briefing cabinet and members twice a week since the beginning of the pandemic with Children's Services being a standing item in all those meetings.

9. The Children's Services Improvement Board continues to maintain robust oversight of the progress the service is making in improving outcomes. Furthermore, since making the transition to the Safeguarding Children Partnership arrangements in 2019, clear priorities and an effective performance framework have been developed to coordinate local work in order to safeguard and promote the welfare of children and to ensure the effectiveness of what the member organisations in Buckinghamshire do individually and together.

10. As a standing member for the Health Protection Board chaired by the CE, the DCS and his corporate and public health colleagues have made sure that support and information for staff across the council and beyond have been consistent including such things as access to PPE, Covid-19 secure working arrangements and vaccinations to name a few. At the time of writing this report, all PRU and Special Schools staff have been vaccinated as a result of prompt decision making locally.

11. We remain alert to changing demand as a result of Covid-19. Our experience to date demonstrates the effectiveness of the approach we have taken and the need to act decisively in response.

Special Educational Needs and Disabilities

1. Statutory performance for assessments has improved from a very low base of 35% in December 2019 to 95% in December 2020.

2. A new SEND Strategy and Improvement Plan has been co-produced with parents and partners and is going through the political process.

3. A quality assurance framework for Education, Health and Care Plans is in place which includes regular multi-agency audits.

4. A 5-year Sufficiency Strategy is being developed with partners.

5. The monitoring of annual reviews by schools is improving and pathways for children preparing for adulthood are being improved.

6. Numbers of caseworkers have increased to ensure that the experience for families improve.

7. The number of complaints has reduced and the experience of schools working with us on SEND has improved.

8. Similarly to early help, a locality based approach to SEND has made a difference to outcomes.

Children in Need of Help and Protection

What we know	How we know it
Children and young people benefit from effective step up and step down processes, to and from Early Help.	Performance data set, both internal and external audit activity with Hampshire.
The MASH has remained effective and is continuing to improve the timeliness of decision making and is able to effectively prioritise on the basis of risk. 89% of contacts have a decision within 24 hours.	Monthly performance data set, quality assurance processes and feedback.
Thresholds are consistently and correctly applied in the MASH.	Quality assurance processes and assessment team feedback.
Timeliness of 45 day assessments is improving. 83% currently.	Performance data set, quality assurance processes and feedback.
Section 47 enquiries are completed in a timely way with a strong focus on risk.	Performance data set, quality assurance processes and feedback.
Visits to children and young people are managed effectively and risk assessed.	Performance data set, implementation of practice standards and quality assurance processes.
PLO work is timely and manages risk effectively.	PLO tracking panel and impact of Court Team on practice.

Areas Requiring Further Attention
Sophisticated thinking and planning in casework needs to be more consistent. Action: Increase confidence of workforce through feedback via managers, QA and learning events.
Continuation of improvement work focused on SMART plans and use of chronologies to inform practice. Action: QA activity using targeted audits and learning events. Confident management oversight.
Increased participation of the partnership in the delivery of plans for children. Action: Feedback to partners, confident social care presence at multi-agency meetings, support from BSPB.

Children in Care and Care Leavers

What we know	How we know it
Looked After Children placed with a parent(s) are safe and benefit from clear planning.	Regular reviewing and HOS oversight, 89% seen on time.
Looked After Children accommodated under Section 20 of the Children Act 1989 have appropriate plans in place.	97% of reviews on time, HOS oversight.
Social workers visits to Looked After Children are in the main timely and closely monitored.	80% seen on time and 86% have management oversight recorded within timescales.
Young people are benefitting from improved and growing understanding of good practice. Social workers and personal advisors generally know their young people well and reflect this in their case recording.	Case file audits and dip sampling, feedback from reviews, changes in recording practices, improved management oversight.
There has been a strong focus on the well-being of children in care and care leavers.	Performance data, including keeping in touch data, review of casework, steps taken to create stability in the team.
Care leavers benefit from a stronger focus on their pathway plans and accommodation needs.	Performance data set, 90% live in suitable accommodation, quality assurance processes, HOS oversight, partnership with Housing, improved outcomes.
Areas Requiring Further Attention	
Improved consistency from managers in their oversight of virtual visits. Action: Ensure there is effective use of team level data set, performance reporting and compliance.	
Improve the consistency of care plans and performance in updating assessments. Action: Continued use of performance management information, audits and IRO oversight.	

Arrangements for Permanence

What we know	How we know it
As at end of December 2020, 21 adoptions completed compared with 19 at same stage last year.	Performance data set
Significant benefit from digital approach to recruitment of adopters has increased approvals.	24 approvals at end of quarter three compared with 11 last year.
Permanency tracking and consideration of early permanency has improved outcomes for children.	Permanency tracking panel, reviews.
Effective placement decision-making and impact of commissioning enable safe placement decisions to be made including clear matching decisions.	Analysis of placement data, evidence of impact of commissioning work, impact and oversight of the Head of Service. Increase in staying put arrangements, increase in Bucks foster carers.
Areas Requiring Further Attention	
Further work to ensure consistency of approach in considering permanency at the earliest possible stage for a child or young person. Action: Feedback from Permanency tracking, audit and QA work.	
Improved placement choice and stability for adolescents. Action: Targeted commissioning work to identify a wider range of good quality placement providers.	

Impact of Leaders

What we know	How we know it
Leaders have a strong focus on the quality of practice and the impact on children and their families.	Quality assurance work, particularly the focus on physical and virtual visits, the work of HOS with their management groups, dip sampling and audit work completed by senior leaders, the embedded use of data to provide a line of sight to specific supervision groups and individual staff.
There has been and continues to be, a strong focus on management and workforce capacity as well as staff well-being.	Response to demand changes, additional social work capacity, intervention in specific teams, individual and group support to staff in response to specific incidents. Corporate and political support.
Leaders have a strong focus on multi-agency working and are prepared to take action to improve outcomes for children and young people.	Progress made on exploitation, work with schools, CAMHS and Police individually and as part of BSPB.
Areas Requiring Further Attention	
Further work is required to continue the consistency of practice across the service, including the use of the Strengthening Families model of practice. Action: Continued learning from audit activity and quality assurance processes.	
Further work is required to enable first and second line managers to build on their existing effectiveness in quality assuring work and supporting professional development of their staff. Action: HOS led work with first and second line managers.	

Focus on the next 12 months

In addition to the specific comments in the previous slides under each heading, we are determined to:

1. Continue to ensure there is stability in the workforce in all teams especially the children in care service for the reasons we have already shared with you throughout the pandemic. This will be achieved by recruiting additional staff, supporting and enabling the current workforce to perform well, continuing the success of the ASYE Academy and continue working with HR colleagues to deliver effective recruitment.

2. Continue to deliver service improvements in line with our Improvement Plan. This will be achieved by maintaining the current robust focus on improvement whilst effectively managing the impact of Covid-19 on the service, the local community and our staff benefitting from the council's public health advice.

3. Complete the planned work on service user engagement to ensure there is even greater involvement of children, young people and their families in service planning, delivery and design building on the success of our approach to SEND in involving young people and their families.

4. Continue to manage well expectations and service demands in the context of the pandemic, whilst keeping our staff safe and healthy and providing them with the guidance, advice and support they require to keep services going during this time.

5. Continue scrutinising performance through various means (scrutiny committee, cabinet, corporate management team, safeguarding partnership, our QA activity and work with HCC) and getting the balance right between challenge and support for our staff across the directorate.

6. Continue our successful partnership working with schools to make sure no children in Buckinghamshire are disadvantaged because of the impact of the pandemic.

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Report to Cabinet

Date: 16 February 2021

Title: Children's Services Improvement Plan Update

Relevant councillor(s): Cllr Mark Shaw, Cabinet Member for Children's Service

Author and/or contact officer: Tolis Vouyioukas, Corporate Director Children's Services

Ward(s) affected: All

Recommendation: For Cabinet to note the continued impact of COVID-19 on the service and the current progress against the Ofsted Improvement Plan.

Content of report

1. COVID-19 continues to be a significant challenge to manage on all levels; however, the service's response to ensure children and young people are kept as safe as possible continues to be of paramount importance.
2. The impact of COVID-19 has led to changes in demand that continue to be unpredictable. This coupled with an increase in the complexity and seriousness of situations that children and young people find themselves in, is having a significant impact on workloads.
3. The challenges created by increases in demand which require our intervention continued throughout the latter part of 2020 and in November specifically, the service experienced a significant rise in demand creating further pressure on the Multi Agency Safeguarding Hub (MASH), Assessment and Help and Protection Teams. In order to manage the changes in workload safely, the service has moved resources to support the 'front door' and has moved casework to create capacity. The Senior Management Team (SMT) has remained focused on ensuring that staff are supported and that standards in practice are maintained. This has been achieved to date in spite of the uncertainty all local authorities face in the current environment.
4. Analysis of our data confirms the changes that the service is experiencing but what is more pronounced are the changes in 'seriousness' of incidents involving children and young people. Overall, there has been a 15% increase in volume of work. The volume of work in Children's Social Care does not follow a uniform pattern and there has been some significant peaks in activity.

5. This increase at this point in time coupled with significant changes in casework that is complex such as sexual abuse, mental health and substance misuse, results in a disproportionate impact on the social work time required to manage each case. The issue of 'seriousness' and peaks of activity comes further into focus when one considers the amount of Initial Child Protection Case Conferences (ICPCC) held in November compared with previous months. There were 93 ICPCC in November 2020 compared with 35 and 25 respectively in October and September.

6. Despite the pressures in the service during the last few months, work on the Improvement Plan has continued. The stability of and steady improvement in the Help and Protection Teams have largely enabled the actions against the quality of assessments and plans to move from red to amber. The Assessment Team Managers, despite being under significant pressure are demonstrating strong management oversight and have maintained strong performance in relation to key performance indicators for Section 47 enquiries. For example, despite increases in volume 85% of all Initial Child Protection Case Conferences are held within timescales, against a target of 78%. The increase in volume of Section 17 assessments has led to a decrease in performance in timeliness, with quarter 3 data showing the rate completed on time has fallen from 84% to 72%. Actions are in place to address this which will lead to performance improvement.

7. The impact on staff of having to frequently deal with disturbing information involving children and young people, consistently working very long hours responding to children in crisis and the overall increase in volume translating into higher caseloads, is significant. Throughout this period of time we have made sure there is a strong management focus on staff well-being.

8. We know that there is always more to do to maintain standards over time and tackle inconsistency whenever it arises. Improvements in the quality of the service provided to vulnerable children have continued despite the current very challenging circumstances. However, it remains the case that the general service to looked after children who are in our care in the long-term is not yet as consistent as we would like. This is reflected in the Red, Amber, Green (RAG) rated plan included as an Appendix. Recruitment of staff who are going to be able to contribute to service improvement remans our top priority.

9. The service is determined to continue to develop and improve, despite what is going on, and be in the best position possible to manage the potential challenges that lie ahead.

Other options considered

N/A

Legal and financial implications

N/A

Corporate implications

N/A

Consultation and communication

N/A

Next steps and review

N/A

Background papers

Appendix 1 – Improvement Plan

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Children's Services

Improvement Plan, December 2020

1. First Response (MASH)

What do we want to see?

1. Professionals identify children and young people in need of help and protection. They make appropriate referrals to children's social care and are able to access social work advice. There is a timely and effective response to referrals, including out of normal office hours.
2. Professionals understand thresholds and this leads to children and families receiving effective, proportionate and timely interventions, which improve their situation.
3. Children and families experience child protection enquiries that are thorough and lead to timely action, which reduces the risk of harm to children.
4. Neglect, sexual abuse, physical abuse and emotional abuse are effectively identified and responded to. Children and young people who live in households, where at least one parent or carer misuses substances or suffers from mental ill-health or where there is domestic violence, are helped and protected.
5. Social workers recognise the factors that can make children more vulnerable and tailor their interventions appropriately. This includes, but is not limited to, disabled children, children who are privately fostered, children not attending school, vulnerable adolescents and children at risk of radicalisation or exploitation or becoming involved in gangs.
6. Children and young people who are missing from home, care or full-time school education (including those who are excluded from school) and those at risk of exploitation and trafficking receive well-coordinated responses that reduce the harm or risk of harm to them. For those who are missing or often missing, there is a clear plan of urgent action in place to protect them and to reduce the risk of harm or further harm.
7. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. Managers in the MASH ensure a timely and effective response to concerns regarding domestic abuse. The recently introduced daily triage meetings provide a forum for reviewing lower risk domestic abuse notifications from the police. These result in timely and appropriate decision-making about next steps, but no record is kept of these important decisions. This has the potential for the assessment of risk or need to not be informed by important historic information.
2. When children need protecting, the response is mostly effective, but the threshold for child protection intervention is not consistently applied. Although managers in the MASH recognise when children are at risk of, or have suffered from, significant harm, strategy discussions are not consistently held in a timely manner, which causes unnecessary delay and leaves children in situations of unassessed risk of potential harm. In addition, in a small minority of children's cases, not all relevant agencies are consistently engaged in strategy discussions, particularly health partners.
3. There is lack of consistent and effective management oversight and supervision.
4. Improve the quality of case recording to ensure that the reader can easily understand the application of thresholds as well as the presenting issues.

Ref	***Outcome***	***Lead***	***RAG***
1.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Manager and Assistant Team Managers	
1.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file.	Team Manager and Assistant Team Managers	

1.3	Cases consistently demonstrate an understanding of the history and take that into account when applying threshold.	Social Workers	
1.4	Analysis and recommendations consistently link to threshold guidance.	Social Workers	
1.5	All relevant agencies are consistently engaged in strategy discussions/meetings to inform identification of risks to children, when assessing the need for child protection intervention.	Head of First Response and Team Manager	
1.6	Staff understand and effectively apply threshold for child protection intervention to minimise delay in convening strategy discussions/meetings.	Head of First Response and Team Manager	

2. Assessment Teams

What do we want to see?

1. Assessments and plans are dynamic and change in the light of emerging issues and risks.
2. Assessments are timely and proportionate to risk, informed by research and by the historical context and significant events for each child.
3. Assessments lead to direct help for families if needed and are focused on achieving sustainable progress for children. Help given to families is proportionate to the level of need.
4. Information-sharing between agencies and professionals is timely, specific, effective and lawful.
5. Decisions are made by suitably qualified and experienced social workers and managers. Actions are clearly recorded. Systematic and effective management oversight of frontline practice drives child-centred plans and actions within the timescales appropriate for the child.
6. Children, young people and families benefit from stable and meaningful relationships with social workers. They are consistently seen and seen alone by social workers if it is in the best interests of the child. Practice is based on understanding each child's day-to-day lived experience. Children are safer as a result of the help they receive.
7. Children and young people are listened to. Practice focuses on their needs and experiences and is influenced by their wishes and feelings.

What needs to change?

1. Improve the quality of assessment and planning to ensure that risk is identified and responded to promptly, especially when risks escalate.
2. Ensure that assessments and plans identify the unique needs and experience of each individual child, particularly when they are part of a large family of brothers and sisters.
3. Assessments, including those of unborn children, are too descriptive of families' circumstances and some lack insight into the child's experience.
4. Ensure that care plans for children reflect their diverse needs and individual identities, and are realistic about achieving change. The quality of children's plans is too variable.
5. There is lack of consistent and effective management oversight and supervision.
6. Social workers do not demonstrate enough professional curiosity to find out what is happening for children to understanding what life is like for them.
7. The quality of children in need and child protection plans is too variable. Plans include too many actions, making it difficult for families and professionals to understand where to focus their attention. In addition, some plans do not explain the consequences or contingencies if the changes are not made.
8. The majority of care plans are not up to date or specific enough to understand the child's lived experiences or the risks and difficulties that they face.
9. Sometimes initial visits to children take too long and there can be gaps in visiting after initial intervention.

Ref	*Outcome*	*Lead*	*RAG*			
			Aylesbury	**Wycombe**	**Chilterns**	**Overall**
2.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers and Assistant Team Managers				
2.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers				
2.3	Where required, cases consistently have succinct, clear chronologies and case summaries which support the reader to understand the child's current circumstances quickly.	Social Workers				
2.4	Assessments effectively identify and analyse risks and needs including current and historic factors, are individualised for each child in the family, take account of the child's identity and routinely consider parental capacity.	Social Workers				
2.5	Robust child-centred plans are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	Social Workers				

3. Help and Protection

What do we want to see?

1. Children in need of help and/or protection have a plan setting out how they will be helped, how their needs are going to be met and how risk will be reduced within the timescales appropriate for the child. If families refuse to engage, clear contingency plans are in place. These are based on the assessment of need and risks to the child.
2. Decisive action is taken to avoid drift and delay. Plans and decisions are reviewed regularly.
3. Alternative decisive action is taken if the circumstances for children do not change and the help provided does not meet their needs, or the risk of harm or actual harm remains or intensifies.
4. Children who need protection are subject to a child protection plan that identifies the work that will be offered to help the family and the necessary changes to be achieved within appropriate timescales for the child or young person
5. Plans address all the identified needs from assessments. They are clear and easily understood. Families understand what is expected of them, and others, and by when and what will happen if they fail to make the expected progress
6. Children, young people and families benefit from stable and meaningful relationships with social workers. They are consistently seen and seen alone by social workers if it is in the best interests of the child.
7. Children and young people are listened to. Practice focuses on their needs and experiences and is influenced by their wishes and feelings. Children, young people and families have timely access to, and use the services of, an advocate. Feedback from children and their families about the effectiveness of the help, care or support they receive informs practice and service development.
8. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. Where stable, frontline managers are in place it is bringing increased rigour in ensuring appropriate supervision and case direction takes place. There is more to do to ensure managers consistently identify and address drift, delay and poor practice.
2. Significant action has been taken to improve the quality of assessments, but too much variability remains. Assessments often lack sufficient analysis to adequately identify need, manage risk and take effective decisions regarding next steps.
3. There is lack of consistent and effective management oversight and supervision.
4. Assessments do not always capture the impact of identity, culture and diversity on children and families' experiences including family dynamics and history.
5. There is inconsistency in the quality and effectiveness of plans within Help and Protection. More work needs to take place to ensure plans focus on clear, time bound interventions aligned to assessed need. Plans should be closely monitored with regular analysis that considers the impact of intervention on improving outcomes.
6. Contingency plans are not always in place, making it difficult for parents and professionals to be clear about the consequences should progress not be achieved.
7. Social workers visit children regularly and in some cases build effective relationships with them, taking time to understand their experiences; however practice remains inconsistent with not all children visited in accordance with their needs and visits are not always appropriately recorded

Ref	***Outcome***	***Lead***	***RAG***			
			Aylesbury	***Wycombe***	***Chilterns***	***Overall***
3.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers and Assistant Team Managers				
3.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers				
3.3	Cases consistently have succinct, clear chronologies and case summaries which support the reader to understand the child's current circumstances quickly.	Social Workers				
3.4	Robust child-centred plans are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	Social Workers				
3.5	Assessments are routinely updated every six months for those under 1, every 12 months for those over 1 and whenever there is a significant change in a child's circumstances. This includes those on CIN plans.	Social Workers				

4. Children in Care and Care leavers

What do we want to see?

1. Children and young people become looked after in a timely manner and in their best interests. Decisions that children should be in care are based on clear, effective, comprehensive and risk-based assessments, involving, if appropriate, other professionals working with the family.
2. All agencies and professionals work together effectively to reduce any unnecessary delay in receiving support and achieving permanence for children.

3. The wishes and feelings of children, and those of their parents, are clearly set out in timely and authoritative assessments and applications to court. Assessments of family members as potential carers are carried out promptly to a good standard.
4. Children's care plans comprehensively address their needs and experiences, including the need for timely permanence. Children's plans are thoroughly and independently reviewed with the involvement, as appropriate, of parents, carers, residential staff and other adults who know them. Plans for their futures continue to be appropriate and ambitious.
5. Children are seen regularly and seen alone by their social worker and children understand what is happening to them. Children have positive and stable relationships with professionals and carers who are committed to protecting them and promoting their welfare.
6. Children in care and care leavers are helped to understand their rights, entitlements and responsibilities. Children and young people have access to an advocate and independent visitor when needed. Care leavers are well-informed about access to their records, assistance to find employment, training and financial support.
7. The local authority celebrates the achievements of children in care and care leavers. It shows it is ambitious for their futures.
8. Children in care and care leavers are in good physical and mental health, or are being helped to improve their health. Their health needs are identified and met.
9. Children and young people make good educational progress at school or other provision since being in care. They receive the same support from their carers as they would from a good parent.
10. Care leavers have timely, effective pathway plans (including transition planning for children in care with learning difficulties and/or disabilities). These plans address all young people's needs. Reviews of plans for care leavers are thorough and involve all key people, including the young person, who understands their pathway plan and contributes to its development.
11. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

What needs to change?

1. The detailed knowledge individual social workers have about their children is not always reflected in the information recorded on case files.
2. Poor historical leadership in both CiC teams has resulted in gaps in knowledge and practice amongst the workforce.
3. There is lack of consistent and effective management oversight and supervision.
4. Actions to address poor practice has led to turnover of staff and caseload pressures. This has not assisted in ensuring that there is consistency and good planning for our children and young people.
5. Achieving consistent levels of compliance has been and remains variable.
6. Audits and case sampling indicate that there needs to be improvements in understanding the history (chronologies), current assessments, permanency tracking and the ability to plan effectively. This is particularly apparent with older long term LAC.
7. Continue to improve the performance to ensure that the health needs of children in care are met through timely health assessments and care leavers have access to their health history.
8. Joint work with CAMHS has and is improving, particularly in relation to local LAC. Challenges remain in some instances for out of county LAC.
9. Responses to changing circumstances of children and young people are not always robust or timely enough.

Ref	***Outcome***	***Lead***	***RAG***		
			CiC	***Care Leavers***	***Overall***
4.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence,	Team Managers and Assistant Team Managers			

	competence and their ability to think critically leading to improved decision making and effective interventions with children and families.				
4.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers and Assistant Team Managers			
4.3	Cases consistently have succinct, clear chronologies and case summaries which support the reader to understand the child's current circumstances quickly.	Social Workers			
4.4	The child or young person's circumstances are reflected in updated assessments prior to each review or equivalent. In the event of a trigger event (such as first missing episode or contextual safeguarding incident) the assessment is updated.	Social Workers			
4.5	Workers have sufficient knowledge and understanding of statutory procedures and compliance.	Head of Children in Care and Team Managers			
4.6	Effective direct work that is linked to the plan and current assessment of need must be evident, with impact on outcomes recorded on the child's case files.	Social Workers			
4.7	Health needs of children in care are meet through timely health assessments and care leavers have access to their health history.	Social Workers			
4.8	Monitoring and visiting arrangements to all children looked after in placements with parents are sufficiently robust to ensure their safety and progress until these arrangements are formally resolved.	Team Managers and relevant Head of Service			
4.9	An effective procedure for accommodating and supporting unaccompanied asylum-seeking children, including those who arrive outside office opening hours, to ensure that their immediate needs and vulnerabilities are appropriately assessed.	Service Director and Head of Children in Care			
4.10	Children in care have a clear permanency plan by their second CLA review.	Social Workers, Team Managers and Independent Reviewing Officers			

5. Child Protection Advisers and Independent Reviewing Officers
What do we want to see?
1. Independent Reviewing Officers (IROs) and Child Protection Advisers (CPAs) offer strong, positive challenge via flexible and supportive actions to drive forward good practice and bring effective, timely support which prevents unnecessary drift and leads to improved outcomes for children and families. 2. CPAs make safe decisions at conferences and ensure measures are put in place to effectively safeguard children and young people. There is evidence of parental and child participation (where appropriate) within conferences, documents and case recordings. 3. CPAs work closely with professionals and families to effectively quality assure initial arrangements for and continued tracking against the child protection plan, overseeing and scrutinising outcomes for the child.

4. IROs apply robust scrutiny which impacts the care planning and review process for each child. IROs are strong advocates for children and young people and work diligently to ensure the child's wishes and feelings are given full consideration and that the care plan fully reflects the child's current needs. They work collaboratively with children in care teams to prevent drift and delay and escalate, when necessary, to ensure positive outcomes for children.
5. Plans to make permanent arrangements for children and young people are effective and regularly reviewed by IROs.
6. IROs challenging any shortfalls in care plan actions and checking the progress of children in between their statutory reviews. They ensure that children are seen and supported to contribute to their review and to influence planning.
7. LADO expertise and advice is available to support other professionals in determining the best steps to take next where there are allegations or concerns about professionals or adults working with children. There is a timely and effective response to referrals and allegations.

What needs to change?

1. Evidence indicates that in the main, IROs and CPAs develop positive relationships with and detailed knowledge of their allocated children but they do not yet consistently challenge deficits in practice effectively. This means outcomes for children have, in too many cases, remained poor.
2. Limited management oversight across operational teams has led to drift, delay and poor practice in care planning. IROs and CPAs need to work more effectively to help secure the right outcomes for children and young people.
3. More work is required to ensure the resolution process for IROs is effective, perceived as constructive and results in proactive, timely responses positively impacting outcomes for children.

Ref	***Outcome***	***Lead***	***RAG***		
			CPAs	***IROs***	***Overall***
5.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Team Managers			
5.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Team Managers			
5.3	Effective care plans and permanency plans aligned to the individual needs of the child/young person.	IROs			
5.4	Active participation from IROs in the updating of assessments prior to each children in care review.	IROs			
5.5	IRO contributions are focussed on improving outcomes for children and young people. Their level of expertise adds value to both casework and social worker development.	IROs			
5.6	IRO oversight considers both the health and educational outcomes of children in care and care leavers	IROs			
5.7	Robust child-centred plans that are SMART, reflect the needs identified in the assessment, timely and reviewed to mitigate against drift and delay.	CPAs/IROs			
5.8	Expert advice in relation to child protection work is consistently evident in case recording and the interventions of CPAs evidence impact on outcomes for children and young people.	CPAs			

5.9	Records of LADO strategy meetings reflect how the integrity of the investigation will be maintained and the decision making of what information to share with whom and when.	LADO			

6. Overarching themes				
Ref	***Outcome***	***Lead***	***Timescale***	***RAG***
6.1	A more stable and permanent workforce than the previous quarter, reducing our reliance on agency workers from 30% (October 2019) to 25% by April 2020 and 20% by September 2020.	HR Business Partner	April 2020	
6.2	What we expect good social work practice to look like in Buckinghamshire features in recruitment, induction and appraisal procedures.	HR Business Partner	February 2020	
6.3	First and second line managers have the knowledge, skills and ability to plan, direct and shape assessments that enable robust plans and strong risk management to be created.	Service Director and Heads of Service	February 2020	
6.4	A fit for purpose electronic recording system, processes and workflows that support good social work practice.	Service Director and equivalent from ICT and Business Intelligence	April 2020	
6.5	All performance management information is based on accurate data, and that managers and leaders use it effectively to measure and inform service improvements.	All CSC workforce and Business Intelligence	April 2020	
6.6	A co-orientated, multi-layered approach to auditing that provides a service wide view of the quality of practice.	Head of Quality, Standards and Performance and SMT	December 2019	Completed
6.7	Case files demonstrate good and effective knowledge of contextual safeguarding which is reflective of a skilled and aware workforce.	Service Director and Heads of Service	February 2020	

7. Early Help
What do we want to see?
1. Early help assessments are timely and proportionate to risk, informed by the family's historical and current context as well as any significant events. Plans are dynamic, changing in the light of emerging issues and risks. 2. Early help assessments inform the development of an agreed action plan and are focused on achieving sustainable progress for the family and children. Support given to families is proportionate to the level of need. 3. Information-sharing between agencies and professionals is timely, specific, effective and lawful.

4. Systematic and effective management oversight of practice addresses deficits in quality and drives child and family centred plans. Management oversight provides clear case direction with actions, rationale and timescales appropriately recorded.
5. Managers within the Family Support Service promptly and appropriately escalate cases where there is significant risk of harm to a child/young person without delay.
6. Children, young people and families are listened to. Practice focuses on their needs and experiences and is influenced by their wishes and feelings.
7. Outcomes are achieved for children and families.

What needs to change?

1. Strengthening the interface between the Family Support Service and the core social work teams to ensure that effective transfer arrangements are in place to step children's cases up or down, according to the level of need.
2. Further work is required to ensure that all partner agencies are consistently providing effective interventions to those children and families requiring low-level support in order to reduce the reliance on the Family Support Service.
3. Early help assessments and plans are mostly comprehensive. The local authority uses a range of approaches, including feedback from children and families, to evaluate the impact of the service. This is making a positive difference to some children's lives but is not yet reaching all the children whom it needs. There is evidence to show that the Family Support Service is now taking a higher proportion of contacts received by the MASH; however, it is too early to determine whether the service is having a demonstrable impact on reducing the number of referrals to children's social care.
4. Performance information is too limited to inform an accurate understanding of the effectiveness of the service.
5. Management oversight of the work allocated to early help within the MASH is regular but is not always sufficiently clear or timebound. When children's cases do get transferred to this part of the service, they are not allocated to specific officers to progress actions, which results in unnecessary delays in progressing some referrals, preventing timely assessment of children's needs.
6. Workers in the early help Family Resilience Service provide a range of interventions to support children and parents. Not all intervention is effective in helping to improve family circumstances, as delays are evident in stepping a small minority of children's cases up to social care when their needs escalate or their circumstances do not improve.

Ref	***Outcome***	***Lead***	***RAG***		
			Aylesbury	***Wycombe***	***Chiltern***
7.1	Regular supervision takes place which promotes a reflective and analytical approach to children and families' needs. Supervision is utilised to increase workers' confidence, competence and their ability to think critically leading to improved decision making and effective interventions with children and families.	Service Manager and Team Managers			
7.2	Regular management oversight to be consistently evident in decision making and easily located on the child's case file. Management oversight should demonstrate the clear rationale, assessment of risk and evidence base for decisions, including the anticipated impact on the child.	Service Manager and Team Managers			
7.3	Where required, cases consistently have succinct, case summaries which support the reader to understand the child's current circumstances quickly.	Service Manager and Family Support Workers			

7.4	Assessments effectively assess family circumstances and identify the emergent needs of children and young people ensuring that appropriate, timely and co-ordinated support can be put in place.	Family Support Workers			
7.5	Robust SMART family support plans reflect the needs identified in the assessment, are timely and collaborative with families and professionals. Plans are reviewed regularly to mitigate against drift and delay.	Family Support Workers			