CHILDREN AND YOUNG PEOPLE
OVERVIEW AND SCRUTINY COMMITTEE

3 June 2014

SAFEGUARDING PEER REVIEW

Report from: Barbara Peacock, Director Children and Adults Services

Author: Sue Brunton-Reed, Improvement Programme Manager

Summary

Medway Council commissioned a Peer Review of children's safeguarding services from the Local Government Association (LGA) in February 2014. This paper summarises the process, the key findings and the planned responses. The letter from the LGA which reports on the Peer Review, and has been sent to the DFE, is attached.

1. Background

1.1 Peer Reviews of children's safeguarding services provide external feedback on the adequacy and effectiveness of local safeguarding services from peers with safeguarding experience and expertise. As part of its commitment to improving services for children, young people and their families, Medway Council commissioned the LGA to undertake a Peer Review of safeguarding services in February 2014.

1.2 The team was led by Eleni Ioannides, former Executive Director of Children's Services for Bury Council, and included a lead member, a health representative and experienced safeguarding managers from several different local authorities.

1.3 Two of the team undertook case and document review prior to the on site work. The team were on site in Medway for five days and met staff and managers from children's services, colleagues from other partner agencies, members of the Medway Safeguarding Children Board (MSCB), observed practice and talked to young people who use our services. A questionnaire was sent to front line staff across agencies, and a multi agency audit group carried out audits of a number of child protection cases.

1.3 The process is intended to provide a valuable external monitoring of progress ahead of any Ofsted inspection and complements the other ongoing evaluations being undertaken by the council, the Chair of the Improvement Board and Department for Education.

2. Focus of the Review

2.1 The Review was structured around key safeguarding themes including:

- Effectiveness of practice, service delivery and the voice of the child;
- Outcomes, impact and performance management;
- Working together with partners;
- Capacity and resource management; and
- Vision strategy and leadership.

2.2 In particular, the council requested that the review examined the effectiveness of Triage and the “front door”, the timeliness and quality of assessments and the consistency of understanding and application of service thresholds across partners. The effectiveness of the MSCB and multi agency responses to child protection enquiries and contributions to child protection conferences, core groups and reviews was also be a focus, as was early help and the responsiveness of partners to prevent escalation to specialist services.

3. Summary of findings

3.1 Strengths

- Energy and focus on the senior management team
- Willingness and attitude of staff to make the necessary changes
- Strong political and corporate support and ambition
- Training and development opportunities for staff
- Focus on recruitment and retention of staff
- Progress in capturing the voice of the child
- Improved performance in key activities including assessment and supervision
- The new structure within children’s social care services, particularly the impact which the Triage and Assessment service has had on the management of referrals
- The use of data and performance information to inform change
- The re-launch of the MSCB.

3.2 Areas for improvement

- The need for continued focus on practice, strengthening assessment and planning activity
- Communication, both internal and external, to make sure everyone understands the improvement journey and their role and area of responsibility

- Maintaining the momentum of change and moving from monitoring compliance to monitoring impact
- Enabling all partners to play their part in promoting safeguarding services which should improve their engagement
- Making sure the key strategic groups (MSCB, Health and Wellbeing Board, Improvement Board, Medway CAN) work together, clarifying governance arrangements and sharing and using information to develop shared priorities
- Support for the Overview and Scrutiny Committee to enable challenge on safeguarding issues
- Embedding plans and strategies and turning them into work on the ground, particularly the development of the Early Help service.

4. Reflections and responses

4.1 The Improvement Board, Corporate Management Team, the MSCB and the Children's Management Team have considered the findings of the Peer Review which were seen to be a helpful and accurate reflection of the current stage in the improvement journey.

4.2 The Improvement Plan has recently been revised and updated (April 2014), taking into account the progress which has already been made and the findings of the Peer Review. The revised Plan was signed off by the Improvement Board in April 2014. Key actions relating to recommendations of the Peer Review include Quality Assurance and auditing processes, practice improvement, ongoing commitment to recruitment and professional development, implementation of the Early Help Service and improved communications. Partners have been involved in contributing to the revised Plan to demonstrate their ongoing commitment to improving services.

4.3 The MSCB is in the process of updating its Business Plan and as part of this process has taken account of the Peer Review findings in relation to communication, challenge, thresholds and information sharing.

4.4 Further work will be undertaken with strategic groups to develop a clear protocol for joint working which clarifies the respective roles and responsibilities.

4.5 An initial review of the safeguarding and challenge function provided by this Overview and Scrutiny Committee over the last eighteen months has identified examples of in depth discussion of safeguarding issues. Further work will now be done to explore good practice in other local authorities where scrutiny impact in improving safeguarding has been demonstrated.

4. Risk Management

4.1 Failure to respond to the findings of the Peer Review and continue our focus on improving services for children and families may place them at risk, will significantly undermine Medway's journey of improvement to date, and will jeopardise future inspections.

5. Financial and legal implications

5.1 There is a financial implication, recognised by the Peer Review findings, which report that investment in Children's Services needs to continue, to embed the practice changes and resolve the historical problems in children's services.

5.2 All recommendations are in line with existing legal responsibilities.

6. Recommendations

6.1 Children and Young People's Overview and Scrutiny Committee is asked to note and comment on the Peer Review report.

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Local Government Association

Barbara Peacock
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2 May 2014

Dear Barbara

Thank-you for taking part in the Children's Services Safeguarding Peer Review. The team received a really good welcome and the co-operation and support throughout the process was greatly appreciated. It was evident to us all that 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 review 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 on-going improvement plan:

- Effectiveness and quality of practice
- Performance management
- Effectiveness of Medway Safeguarding Children's Board
- Leadership and management

These areas of focus are incorporated in our findings under the relevant key themes.

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 to us on safeguarding

vulnerable children and young people. The front line questionnaire, audit validation report and case records review, along with the other documentary evidence provided to us, was used in our focus on assisting you in your on-going improvement.

You decided to take up the optional element of an audit validation exercise and the Case Records Review which was completed prior to the main review and on-site. The reports for both the audit validation and case records review evaluate the quality of casework, care planning and supervision and are appended to this letter. In particular, the case records review and audit validation, linked to your case mapping exercise, validated many of the peer team's findings in relation to frontline safeguarding practice. The evidence we obtained from these elements contributed to the team's overall findings, which also included evidence from interviews, performance data, documents reviews and focus groups with staff and partners.

Executive summary

The Peer Team were impressed with the level of energy and focus that the new senior team were demonstrating, with considerable political and corporate support, and appropriate ambition for the children of Medway. The appointment of a permanent senior management team, committed to Medway and viewing the challenges ahead with determination and optimism has been powerful and a necessary precursor to further improvement activity. Much purposeful activity is taking place to resolve some long standing quality issues. We heard about the impact of previous lack of leadership in this area and staff were in the main pleased to be receiving clear direction and support, the opportunity to engage in service improvements and to identify barriers to success. The strong drive for training and development opportunities is appreciated and valued, as is the determination to appoint only the best candidates available.

Many of the issues of concern raised were already being dealt with, or planned for. However, this is indicative of the scale of the task that still lies ahead. There is a legacy of historical cases of drift and poor planning which will take some time to resolve, alongside dealing with current increasing demand. The authority has rightly focussed on recruitment and retention in order to create the capacity for change, but competition for staff in the area is strong and this will continue to be a difficulty and to hold back progress. The authority has invested in temporary agency staff as appropriate to ensure cover, and we heard of commitment to continue to prioritise funding to ensure child safety.

To realise their ambitions, senior managers and politicians have been driving a range of reviews and changes in services. Whilst this pace is necessary, it is important to recognise the impact of the multiple changes on staff and partners, and to ensure that all changes are fully explained and communicated in a timely manner. Now that many of the required structural changes are being achieved, even more of the focus can be directed to front line practice to continue the strength of the drive to improvement in assessments and plans, ensure appropriate recording and to focus on the journey of the child.

Relationships with partners are good but there has been insufficient challenge and joint delivery in the past, particularly at the MSCB. The new Chair has a clear vision for the work of the Board, and partners are willing but will need to take a more active part in planning and delivering together for the children and young people of Medway, especially around early help, domestic abuse, pre birth work, emotional health and wellbeing and compromised parenting. Given that resources for all partners are under severe pressure it will be increasingly important to consider how you can all work together to deliver more efficient and effective services.

Many improvements are still at planning stage or early implementation including:

- Social Work Academy and Leadership Development programme
- Advocacy for children in child protection work
- Creative recruitment including recruitment from abroad
- Development of Triage to become multi-agency advice service
- Co-location of social work teams
- Agile working methods for social workers
- Big Lottery bid
- Live pupil progress data through system link up with schools
- Development of risk assessments fro adolescents
- Medway Safeguarding Children's Board newsletter

There is much still to be done, particularly in driving the changes down to the front line. It is too soon to show the impact of most changes. This will continue to be difficult due to the ongoing recruitment and retention issues which are only able to be dealt with slowly. We recognise the considerable activity that has taken place in terms of the visibility of senior managers and politicians; newsletters, roadshows and other opportunities. However, we would support continued focus on communication in order to ensure full understanding of the vision, the changes and the requirements. We wish Medway well on their improvement journey, and would encourage the direction of travel they are taking.

Summary Strengths

- Good progress has been made in capturing the voice of the child, not only in case conferences but also in assessments where children are being seen and appropriate tools used to capture their voice. The MSCB is also focussing on children's lived experiences at each meeting. There has been a reduction in re-referral rates which suggest that timely and more effective assessments with appropriate interventions are having an impact together with the effective embedding of the Triage service. There are good and outstanding Children's Centres which provide innovative and thoughtful provision which meet local needs.

- There has been a range of improvements in the area of performance. This includes performance around Child Protection plans and also the improved trust in performance data which meets the needs of managers in making improvements in their teams and at an individual level. Supervision is more evident and there were examples of reflective practice. You are also learning from others through benchmarking and visits to other local authorities to look at good practice. .

- There is a willingness for all partners to work together to safeguard children and there were examples of positive working relationships in both Police and Health. Partners are prepared to take responsibility for leading sub-groups of the MSCB to ensure a multi-agency approach.

- There has been a recognition of the importance of investment to realise your ambitions for the children and young people of Medway. Additional social workers have helped to reduce case loads and additional demands are being dealt with. Investment in technology and better working practices has resulted in efficiencies in the service which enables you to target resources where they are needed most. The emphasis on recruitment and retention through the 'Make a Difference' brand is starting to have some success. The active management of competency issues is seen as a positive step and you have been supported by dedicated HR resources which have been appreciated by managers and employees.

- There is confidence in the senior team and a clear sense of direction. Senior managers are visible, approachable and staff feel listened to. Strong political support from the Lead Member, backed by the Leader and the Cabinet has ensured investment in the service. Corporate support for the service was evident demonstrated by the allocation of dedicated corporate resources to Children's Services. Where services were no longer fit for purpose they have been restructured and culture change is apparent and continuing although this will take time and needs to ensure that it engages the hearts and minds of all employees.

Summary Areas for Consideration

- The quality of casework remains varied and it is crucial that systems across children's social care maintain the focus on improving outcomes for vulnerable children and 'getting it right first time.' A range of improvements need to be progressed around chronologies, assessment tools, quality of reports, and the understanding of thresholds. There were particular concerns around very late planning for unborn children. Practice needs to be improved and this should include pre-birth assessments and birth plans. The team found limited evidence of knowledge amongst staff from all agencies of the impact of the Toxic Trio (adult substance abuse, domestic abuse and parental mental health) on the safety and welfare of the children. Strengthened joint working is required across Adults and Children's Services to achieve positive outcomes for children. There is a need for all partners to understand how information can and should be shared to ensure appropriate safeguarding which is a key aspect of 'Working Together 2013'.

- A great deal of effort has been focussed on compliance and 'how much are we doing'. The focus must be directed towards the impact on children's lives and on 'how well are we doing' through the improvement in the quality of assessments and plans and concentrating on outcomes for children and their families. Auditing of case files has improved but there must be SMART recommendations from audits that will feed into improved practice. There is also a need to 'close the loop' on actions from audits to ensure that improvements have been implemented. Performance data needs to be developed further to produce trend data which will better inform service planning and delivery. The joint data set agreed by the MSCB should be developed to provide a robust evidence base for the planning and commissioning of services.

- There are a number of issues that need to be addressed by the MSCB:

    - Partners need to be enabled to provide each other with constructive criticism and challenge

    - Membership of the board needs to reflect the contribution of all partners

    - Promotion of the early help offer is required and it is vital to ensure that all partners understand what this is and who has the lead responsibility

  A development day to establish the purpose of the Board and identify priorities and risks will begin to address these issues.

  Overall, it was difficult to determine the governance arrangements between the MSCB, Health and Wellbeing Board and other partnerships including the Improvement Board and CAN. This is causing confusion amongst some partners and improved short, clear and consistent communications will help

partners to understand who is taking the lead on initiatives and what their role is in improving outcomes for children.

- With all public sector partners facing reduced budges there is an opportunity for more joint commissioning and the aligning or pooling of budgets as well as a need for smarter, joined up thinking and this could be explored and led by the MSCB. Investment in Children's Services needs to continue as there are a range of initiatives that need to be embedded and historical problems resolved and this cannot be achieved immediately. There are still high levels of vacancies and a continued effort to recruit and retain good quality staff is required by increasing the emphasis on learning and development opportunities.

- Although significant effort has been put into communicating with employees this has also created issues around information overload. It is vital that communication should be short, regular and fully understood and this understanding should be reviewed to ensure the engagement of everyone, especially employees in front-line practice.

The impact of Children and Young People's Overview and Scrutiny on safeguarding was not easily recognised. Support for the Chair of Overview and Scrutiny to enable challenge on safeguarding issues would strengthen the role of Overview and Scrutiny.

Many of the strategies in Medway are not yet written, are newly written or are still in draft. We would recommend an audit of strategies you have in place to identify which need writing, which need reviewing and which need embedding.

Actions you may wish to consider as a result of the review could include:

- Arrangements for case auditing need to be prioritised and this should feed through to staff development and the monitoring of improvements to ensure quality increases.

- A review of best practice for pre-birth assessments and birth plans and incorporate these into practice with regular monitoring on their implementation and use.

- The commissioning of training on Toxic Trio and joint working to minimise impact. It would be advantageous to set up a small project group to consider the issues and bring recommendations for better joint working.

- The MSCB could initiate a review of the information sharing arrangements and develop revised protocols.

- The continued need to promote, communicate and discuss the thresholds documentation.

- The development of data sets that show trends over time rather than snapshot data.

- Completing the work on a robust early help strategy, engaging all partners. The MSCB should seek assurance from each agency that they have identified sufficient resources and can indicate their contributions within their own strategic planning.

- The development and monitoring of the effectiveness of the learning and improvement framework including Section 11 audits and their impact.

- The development and promotion of governance protocols between the MSCB, HWB, Improvement Board and CAN. In addition, the mapping out of their respective leadership areas would improve understanding of their respective roles and responsibilities.

- Assessing the potential for improving services for children and families through joint commissioning and pooled budgets and make recommendations about priority areas for consideration.

It was clear that many of the right things are being done, and at pace. Maintenance of momentum and the embedding of change throughout the organisation are still required. There is a lot still to do It is unfortunate that the Peer Review came before many of the changes and initiatives have yet had a chance to impact further on practice and on outcomes for children and young people. The authority may wish to commission a further review in six months time to assess the distance they have travelled on their improvement journey.

Following the team's presentation on Friday 28 February, and the question and answer session that followed, you then ran a prioritisation workshop with a range of staff and partners. The review team stayed for part of this session.

You considered the following areas in groups which were pertinent to the review and your improvement journey:

- Internal and external communication about the improvement agenda and safeguarding practice.
- Partnership working
- Thresholds/Early Help
- Parental mental health and substance misuse
- Performance management

We wish you well with taking your decided priorities forward.

You and your colleagues will want to consider how you incorporate the team's findings into your improvement plans, including taking the opportunity for sector support through your regional arrangements or the LGA's Principal Advisor Heather

Wills, e-mail heather.wills@local.gov.uk Telephone No. 07770 701188. I know you had initial discussions with Heather at the feedback meeting.

The review team also offered to assist with sample templates if required and these have now been collated and sent to you which I hope you will find helpful.

Once again, thank you for agreeing to receive a review and to everyone involved for their participation especially Michelle Lofting and her team for their excellent support and assistance during our week on-site.

Peter Rentell

Programme Manager (Children's Safeguarding)

Local Government Support

Local Government Association