

Laura Johnston
Director of Children's Services
Telford and Wrekin Council
Addenbrooke House
Ironmasters Way
Telford
TF3 4NT

25 July 2013

Dear Laura

RE: CHILDREN'S SAFEGUARDING PEER REVIEW

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

We agreed to send you a letter confirming our findings. As you know the safeguarding review focused on 5 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

In addition to and within these overall areas, you asked the team to explore the following issues:

- How well are the racial, cultural and linguistic identity and needs of children and young people from minority ethnic communities and their families identified, and how well are they reflected in decision making and care planning?
- How well are early help arrangements improving outcomes for children and young people, diverting them from care while ensuring they are kept safe?
- Can we be confident that the planned reduction in numbers of children on a child protection plan has been achieved while ensuring children are safe?
- How well are early support processes, including Family Connect and the triage system, ensuring children and young people receive the right help at the right time whilst ensuring a timely response regarding those in need of protection?
- How effective are our social work processes around recruitment, induction, supervision and skills development?

- How effective are the new NHS arrangements in terms of safeguarding?

The team's summary findings on these additional areas are provided at Appendix A.

When preparing for the on-site element of the review, the team identified two further areas it wished to explore:

- Improving the quality of provision is essential if Telford and Wrekin Council and its partners are to ensure safeguarding. How secure are the recent improvements?
- Are there effective procedures, systems and behaviours in place to hear the voice of the child and parents, pool information and see the bigger picture in safeguarding issues?

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

It is important to stress again that this was not an inspection. A team of peers used its experience to reflect on the evidence you presented on safeguarding vulnerable children and young people. All the documentary evidence provided to us was used in our focus on assisting you in your on-going improvement.

You took up the optional elements of an audit validation exercise and a case records review. The team's reports in respect of these are attached in appendices B and C to this letter. The team's observations about practice concerns and management oversight are set out in the main body of this letter.

Executive Summary

The peer review team were impressed with the strong passionate and clear commitment demonstrated by senior council officers, Members, partners and staff to delivering positive outcomes for children. There is little doubt that the DCS and Lead Member have high aspirations for service delivery but to achieve these it is important to clearly articulate what the vision looks like and that the pace of systematic improvement is maintained and increased where possible. There are opportunities to strengthen the links between plans priorities and performance reports with greater focus on outcomes and deliverables. This would enable you to tell your improvement story with confidence.

Together you are taking action to address areas for improvement identified by Ofsted in your Safeguarding and Looked after Children inspection in 2012. Performance against national indicators is mainly in line or above the England average. CAF remains work in progress and there still is a need for an agreed and widely understood description of early help and how partner agencies should contribute. Further work is needed by partner agencies in understanding their role in providing support and alleviating pressure on social care.

The development of your innovative family connect (a collaborative integrated front door service) has been positively received and is well-regarded but attention needs to be directed toward developing a shared understanding and clarity of the processes for distribution of work following family connect which allows for appropriate and timely access to services.

Staff in the Children & Family Locality Service (0 to 19) have seen an increase in demand for their service since the implementation of redesigned children services in 2012. This has given rise to some capacity issues and training needs for staff in this area

The flow of work, prioritisation and risk throughout the redesigned services should be fully evaluated and assessed to understand capacity, resource issues and to inform your developing commissioning activity. The lack of analysis and planning can sometimes mean going directly from information to action. This can be seen where changes to services are implemented without full consideration of the impact those changes will make. This then requires further remedial actions creating additional work for staff and confusion for others: for example, Telford Leaving Care services. The peer review team identified some evidence that data is beginning to be used to drive better outcomes for children and young people but there is not as yet a systematic approach to analysis to inform practise.

The need to develop a performance culture is an increasing focus at senior level across the partnership and there is a need to develop a multi agency performance framework which will allow challenge and inform the partnership in terms of impact and opportunities for future service design. It is important that all staff understand success factors and that there is clarity about thresholds and continuum of need.

Relationships are strong and collaborative across the partnership at both the strategic and operational levels. These partnerships are capable of delivering effective responses to difficult situations e.g. Operation Chalice, yet there are weaknesses in some aspects of service delivery for children and young people: for example CAMHS, where although there has been consistent challenge at a strategic level this has not resulted in a timely improvement in the service. Despite the many changes within the Health family in Telford and Wrekin there was evidence of clear processes and assurance pathways for safeguarding and an acknowledgment that improvements are needed with adults mental health and G.P.s

There is a need to develop a strong culture of effective challenge for partners to hold each other to account for agreed actions. The changes to the governance arrangements across the partnership provide the opportunity for all partners to give constructive and effective challenge leading to timely action in future. This is particularly so in the proposed redesign of the LSCB governance arrangements under the leadership of the new chair.

There is a strong commitment from the political leadership in keeping children safe in part demonstrated by the financial support given to the service to deal with increased referrals and LAC numbers. Effective formal mechanisms are in place for engaging elected members by the new Cross-Party Corporate Parenting Group, which is led by

the Lead Member for Children and includes representatives of the Scrutiny Committee in the membership.

Commissioning across the council and partnership is in early stages of development and more work is to be completed to bring coherence to this. Public Health's contribution to this agenda has yet to be maximised.

The peer review team found evidence in cases indicating that children are listened to and there are established networks of engagement with children and young people where they are encouraged and supported to contribute their views. The council may wish to consider developing a systematic way of collating and capturing impact; to clearly demonstrate that what is said is heard

Improvements in case file audits developed and piloted this year are still in embryonic stage and will require continued work to embed within and across the service. You are beginning to develop ways of learning from the audits and from serious case reviews so practise is consistently shared across the children's workforce.

As mentioned above, the peer review team raised a further two questions for consideration, although much of our findings address these two questions we would make the following points:

We asked " Improving the quality of provision is essential if Telford and Wrekin Council and partners is to ensure safeguarding .How secure are recent improvements?"

Considerable effort has gone into service redesign since the inspection in 2012, but the changes are only just beginning to demonstrate impact and there is still some bedding down of processes to take place. Overall the picture is mixed. There is a need to tackle unallocated cases at lower levels of need, make best use of early help and reduce LAC numbers. Processes and systems to facilitate consistency of practise within social care are still embryonic and require further testing and application both in audit and reflective practise. The recently appointed improvement officer and the principal social worker are resources which should be maximised to bring pace and application to these areas. Across the partnership there is a lack of rigour in performance monitoring. This is apparent within LSCB although there is a recognition of and intention to deal with the issues.

We also asked "Are there effective systems and behaviours in place to hear the voice of the child and parents, pool information and see the bigger picture in safeguarding issues?"

The peer review team saw some evidence that the procedures, systems and behaviours are in place within Social Care and across the partnership to hear the voice of the child and parents. Again, however, there is a recognition that there remains more to do to ensure a consistency of application. The partners have demonstrated ability to respond to difficult challenges and they should use and apply this learning to help achieve consistency.

The main strengths and areas for further consideration presented to you were as follows:

Summary Strengths

- Very committed and effective social workers and staff across the partnership
- Increasing recognition for need for data analysis to inform practice and maximise positive outcomes for children and young people
- Lots of support, collaboration and commitment across the partnership
- Effective Recruitment strategy achieving reduction in agency staff and stability of workforce
- The Council's Medium Term Plan reflects its commitment and willingness to fund safeguarding
- Aspirational leadership across the partnership
- DCS and Lead Member held in high regard across the Council and the partnership as a whole

Summary Areas for Consideration

- Commissioning is underdeveloped across the partnership
- Integrated practice is still emerging
- Ensure reflective practice is captured in case recording
- Further develop the effectiveness and awareness of the “early help” offer across the Council, partners, children and families
- Lack of analysis and planning can sometimes mean going directly from information to action
- Ensure that all partners give constructive and effective challenge leading to timely action when necessary
- Greater focus and increased pace of effective change
- More clearly map the relationship between aspiration and frontline practice and help make it come alive for staff

Detailed Findings

The table below highlights the positive aspects noted by the peer review team and areas for consideration by Telford and Wrekin Council and its partners:

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| <p>Effective practice, service delivery and the voice of the child</p> | <p>Strengths:</p> <ul style="list-style-type: none"> • Family Connect is an innovative approach and is generally viewed positively across the partnership. • Partners reported good responses including access to the Duty Social Worker. • Parents are reported as not regarding the Family Connect service as being simply social care and this is felt to be strong and helpful message. • There are some very able and committed |
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| | <p>practitioners who clearly have children's interests at the forefront of their practice.</p> <ul style="list-style-type: none"> • The recent restructuring of the CiC team into groups and "joint ownership" of cases has been positively received by frontline staff, as has the introduction of weekly group meeting. • Front line staff have access to services such as Family Group conferences which are felt to be effective when working with families, when utilised • Case records evidence some social workers knowing the child as an individual and ensuring their views are represented in plans. • Senior Managers are actively involved in key decision-making points in the child's journey. i.e. the decision to accommodate, to issue proceedings or submitting the final care plan to court. • There is a commitment to reflective practice and continuous professional development. Front line understand the benefits of reflective supervision and seek out opportunities to engage in this • Newly qualified social workers are well supported, particularly in teams where there is an Advanced Practitioner, and have good training opportunities available to them. It would seem that this has contributed towards stability • There is a high level of business support in most social work teams • Emerging understanding of the need to collect data on diversity to inform planning of services. • All referrals to Family Centres are offered an initial interview to ensure any 'quick fix' issues can be addressed to avoid any lengthy wait for their services • Voice of the child heard through the formal processes of LAC reviews and taken to foster Panel. • There is evidence of the virtual elimination of the reliance on bed and breakfast accommodation to meet the accommodation needs of care leavers. • The planned rollout of training in Systemic Practice affords a significant development opportunity to staff, and demonstrates a large |
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investment by the council.

- Training for health practitioners on the impact of factors such as alcohol / drugs on parenting has increased knowledge and understanding and confidence in referring to social care.
- Very positive relationships with the police, including community support, who are always available for discussion or joint visits.

Areas for further consideration:

- Practice and procedures need to facilitate social workers' direct work with children. Front line staff wish to increase the time available to work directly with children and some have the skills, resources and support to do so. However, some social workers felt that they were not able to prioritise direct work with children and families and regretted that this was so.
- Social workers felt Family Group Conferences were not routinely considered as part of the range of options available and that a more consistent use of them could be helpful in identifying family support/alternative carers sooner in the child's journey.
- The balance between ensuring that senior managers are aware of, scrutinise and offer challenge at key times and ensuring that the process for doing so does not become too bureaucratic or distracts from case work decisions being made at the appropriate level needs to be assured.
- Build on commitment to reflective practice and ensure it is evidenced in case and supervision records. Social work staff and managers who the peer review team met were clearly very engaged and committed and, in discussion demonstrated that reflective practice was used. However, this was not evidenced in the case records which also did not show how key casework decisions were made and the role of managers in making these decisions.
- Redesigned services will not of themselves

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| | <p>guarantee improved performance and better outcomes for children. The allocation process with 0-19 Services is unclear between teams creating duplication. There are a number of unallocated cases.. Whilst there is a strategy in place for dealing with unallocated cases, there is not an identified strategy to eliminating these cases</p> <ul style="list-style-type: none">• Evaluation of impact of changes to services may help to get things right first time• The differing professional roles/levels of other agencies' staff within Family Connect could benefit from further consideration• There is not currently an intention to rotate social work staff working on the duty desk in Family Connect - and at least one is newly qualified. This presents a potential of de-skilling workers or of not having staff on duty with current operational experience.• Little evidence in the peer team's discussions with workers and on case records of consideration of cultural, spiritual and religious needs. Staff acknowledged that they were not confident in addressing children and families' racial and cultural needs and felt that this was an area in which they needed support and training.• Further develop the use of Advanced Practitioners to build on the support and supervision they give to newly qualified social workers.• Share good practice and resources for direct work with children between all social work teams and partner agencies.• Improve opportunities for training for experienced social work staff and make training available to all members of social work teams.• Engagement with young people leaving care to be developed to ensure their voice is heard and effective leaving care pathways are agreed. Care leavers expressed a range of concerns about the preparation for independence and the subsequent support they received. Of particular |
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| | <p>concern was whether the opportunity to “stay put” with foster carers exists. Consideration could be given to measuring the impact of the groups in the CiC team on the young care leavers.</p> <ul style="list-style-type: none"> • Dissemination throughout Telford & Wrekin offering clarity about services available to children and young people who are at risk of coming into care would be helpful to staff. • All partners need to focus on the lack of availability of CAMHS services • Ensure there is sufficient capacity in Child and Family Locality Services (CAFLS) so that cases stepping down from Children’s Social Care can be allocated within CAFLS in a more timely way, enabling the case to be closed to Children’s Social Care more quickly |
| <p>Outcomes, impact and performance management</p> | <p>Strengths:</p> <ul style="list-style-type: none"> • Increasing recognition of the need for data analysis to inform practice and maximise positive outcomes for children and young people. The Child Protection Conference Chairs had considered and analysed the reasons for the reduction of numbers of children subject to child protection plans. They felt the main reason was improved practice - both from themselves in ensuring that only children who continued to meet the threshold of significant harm stayed subject to a plan and from social workers who were coming with a better prepared plan to present to conference. • Quality Assurance framework is in development and inclusive of staff in the design and dissemination. Managers and front line staff are engaging with the audit processes and are committed to improving practice. • Evidence of using management information to drive better outcomes: e.g. LAC health and dental assessments. Good work has been undertaken to improve the timeliness of LAC health and dental assessments • Performance in many areas is higher than |

national indicators: e.g. stability of placements, percentage of child protection conferences reviewed in timescales, LAC attainment Key Stage 4.

- The appointment of a dedicated Children's Service Improvement Manager demonstrates a commitment to improving outcomes for children.
- Teenage pregnancies of CiC relatively low. Evidence of sourcing suitable placement to meet needs of the young person and child.
- Evidence of Scrutiny Committee impact: for example, LAC placement report, cost improvement plan.

Areas for further consideration:

- The flow of work prioritisation and risk throughout the redesigned services should be fully assessed and managed. There are unintended consequences of the service redesign on allocation across the system, some issues of processes leading prioritisation and evidence of risk avoidance in the management of demand.
- Develop a comprehensive approach to evaluating impact of service developments on outcomes. Consideration should be given to undertaking an exercise tracking cases from decision -making in Family Connect to outcome. This would help to more fully understand the journeys cases are taking and inform decision-making about the re-allocation of resources and the further redesign of services (e.g. the disbanding of the Child Protection Team)
- Accelerate development of multi-agency performance framework. The LSCB has plans to develop a multi-agency outcome-focussed performance framework. This work should be accelerated and embedded as soon as possible.
- Introduce systematic analysis of indicators related to ethnicity and religion, with particular focus on representation in the systems and outcomes. Although management information is available, it is not being made full use of. Information in relation to ethnicity and religion is one example of that. Information was available in

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| | <p>the data provided to the Review Team regarding the representation of minority ethnic children in the Looked After and child protection systems but it was evidenced in conversation that this was not being actively considered and used to inform actions.</p> <ul style="list-style-type: none"> • The QA framework and recently developed case record audit needs time to embed and be evaluated before an accurate assessment of its impact can be made • The offer of 'early help' by the community social work team and Family Centres is being diluted by the emerging complex needs of families referred to them • Health assessments of variable quality for children placed out of Telford & Wrekin, particularly for those with complex health needs. • Consideration to be given to involving local health commissioners earlier in the process. • Recent discussions / agreements across senior partners concerning thresholds needs to be communicated to front line staff. • Family Connect to ensure all referrers receive written information of the outcome of their referral within agreed timescales. |
| <p>Working Together (including Health and Wellbeing Board)</p> | <p>Strengths:</p> <ul style="list-style-type: none"> • HWB and CCG governance have clear assurance pathways following Health Service redesign with Memorandum of Understanding with Shropshire CCG • New Chair of Telford and Wrekin SCB providing fresh perspective with significant opportunity to drive through change. • Partner support and involvement is evident within Telford and Wrekin SCB. There are examples of positive and effective working across partnership |

at all levels. The Family Cohesion Service is a practical example of where a service can demonstrate effective partnership working.

- Partners report positive working relationships with police. There are opportunities at a strategic level to demonstrate engagement with the Police service for example through a contribution to the Children's Service Improvement Plan. Partners report very good engagement with the Police at operational level.
- Work in progress in developing multi-agency audits.

Areas for further consideration:

- There needs to be effective challenge to resolve identified key issues (such as CAMHS, equality and diversity). The Council and partners have responded well to difficult and significant issues, but this is not a systematic approach.
- The disconnection between strategic aspirations and front-line delivery should be addressed, making the vision a reality for staff.
- Improvement is needed in data analysis and collection to inform decision-making across the partnership.
- Further development of some adult services engaging with safeguarding – GPs and Adult Mental Health teams
- Further develop the awareness of the “early help” offer across the Council, partners, children and families. There is an ‘early help’ offer that is understood within the Family and Cohesion Service. However, it is not fully understood across the wider children and family services or by some key partners within the Voluntary and Community Sector or schools.
- Take advantage of the opportunity presented by revised governance structures to clarify expectations of individual partners and boards. This will enable difficult and challenging discussions and actions to be taken.

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| | <ul style="list-style-type: none"> • Explore how to improve designated and named professionals' efficient and effective working with two safeguarding boards across the health economy • Work with relevant staff to ensure their work across two LA's is as efficient as possible. • Walk in GP surgeries use different IT systems and do not receive 'alerts' of children subject of CP plans. Use of locums in these surgeries is high. • Some regional commissioning such as Forensic Examination Centre has not fully involved all partners, so ensure designated professionals are involved in the review of the service. |
| <p>Capacity and managing resources</p> | <p>Strengths:</p> <ul style="list-style-type: none"> • The council's long term financial strategy recognises need to meet challenge of future funding of children's services. • Safeguarding is a high priority for resources, with extra investment provided where necessary. • Well-managed process of identifying on-going efficiency savings via Cost Improvement Plan. • Ambitious Workforce Development Strategy beginning to show impact e.g. more stable workforce due to overall reduction in agency workers. • Training generally well regarded by partners, including schools, IROs. Partner representatives report favourably on the high standard and value for money of the training available to schools. Provision is described as being of a very high standard and available throughout the year. Timely general training on safeguarding is offered. The Local Authority Designate Officer (LADO) has strong links with schools. <p>Areas for further consideration:</p> <ul style="list-style-type: none"> • Need to maintain focus on reducing the number |

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| | <p>of children coming into care.</p> <ul style="list-style-type: none"> • Need for a more coherent approach to commissioning, particularly in early help, across the council and across the partnership to reduce duplication and increase understanding • Accelerate work to develop model of evaluating preventative interventions, based on impact and cost, to inform commissioning • Continued issue of serious under-capacity in CAMHS. The revised governance arrangements described above between the Children Young People and Families Board and its executive members the Local Strategic Partnership, LSCB and the Health and Wellbeing Board, afford an opportunity and a 'litmus test' to demonstrate that partners can resolve complex issues such as the long standing under-capacity relating to Child and Adolescent Mental Health Services. |
| <p>Vision, Strategy & Leadership</p> | <p>Strengths:</p> <ul style="list-style-type: none"> • Aspirational vision for children in Telford and Wrekin with safeguarding being given high priority by all partners • Committed and visible political and managerial leadership focused on improving outcomes for children. There is a clear accountability framework within the Council – Leader, Lead Member, Managing Director and Director of Children and Family Services. The Scrutiny Committee is providing important challenge. • Collaborative relationships across the partnership with the willingness to do more. This provides a strong foundation for developing the work of the partnership • Strong understanding of corporate parenting and safeguarding is taken seriously across the partnership • Developing culture of positive childcare practice to facilitate consistency |

Areas for further consideration:

- The vision for Telford and Wrekin’s children and young people would benefit from wider dissemination and debate. There was some evidence of a disconnection between the front-line staff and the aspirational approach of senior managers. Staff felt some consultation was tokenistic and also that on occasions changes were introduced without sufficient consideration of the impact.
- The new arrangements in the Children in Care service - with the reorganisation of two teams into three “groups” - have been cautiously welcomed by staff with whom the team spoke but it was felt that the changes had been introduced with insufficient preparation.
- Increase the pace and impetus in driving change with focus on key areas: some necessary changes are taking too long to implement.
- Build on the pockets of effective practice where the voice of children, young people and families impacts on priorities
- Bring focus on the “early help” offer, and especially the part to be played by other partners in the delivery of early help and in CAF.
- Add impetus to co-operative commissioning activity across the partnership to deliver “early help”. There are opportunities for further engagement with the Voluntary Sector to help it develop its infrastructure and contribute to co-operative commissioning activity.
- Public Health can assist in maximising outcomes for children and young people. We advise Telford and Wrekin ensures the potential Public Health presents in the Children’s agenda is fully realised.

Following the team's presentation on 7th June 2013 and the answering of immediate questions, you then ran a prioritisation workshop with a variety of stakeholders. You adopted a "light touch" approach on this, recognising that attendees were valuing the opportunity to discuss questions and the team's observations.

The workshop was participative, with four groups each exploring two of the summary areas for consideration. Following an interactive dialogue each group then fed their respective discussions and ideas back to the wider audience. This feedback will be developed and integrated into the action plan stemming from the review: a smaller group commenced work on this after the workshop.

We wish you well with taking these priorities forward. The Local Government Association is offering a follow up visit within the next 12 months after the peer review. This would give us both an opportunity to evaluate the process and assess impact. You and your colleagues will want to consider how you incorporate the team's findings into your improvement plans, including taking the opportunity for sector support through your regional arrangements or the LGA's Principal Adviser, Howard Davis who can be contacted by either email: howard.davis@local.gov.uk or by phone on 07920 061197.

Claire Burgess, Children's Improvement Adviser, has been sent a copy of this letter and will be in touch with you to discuss the options for support and how best to share notable practice identified. Claire can be contacted by either e-mail: Claire.burgess23@gmail.com or by phone on 0785 440 7330.

Once again, thank you for agreeing to receive a review and to everyone involved for their participation. In particular, please pass on our thanks to Tilly Heigh and Julie Gradwell who provided sterling support in both the preparation of the review and during the on-site review week.

Paul Curran

**Children's Improvement Adviser (Peer Review)
Local Government Association**

Appendix A: Key Areas of Focus

- **How well are the racial, cultural and linguistic identity and needs of children and young people from minority ethnic communities and their families identified, and how well are they reflected in decision making and care planning?**

Our view is that this is not sufficiently at the forefront of people's minds. There is a need to increase staff confidence in dealing with these children and their families. There is an absence of evidence that needs are reflected in decision making and care planning

The review team found little evidence of recording within data of information specifically relating to children from an ethnic minority group. Discussions and meetings within groups demonstrated little knowledge of the size or composition or trends of groups and whether they were under or over represented in data. A good example relates to the Looked After Children population.

As recording of racial, cultural and linguistic needs is not yet fully embedded or systematically undertaken, it is not possible for the review team to comment on the degree to which they are identified and reflected in decision making and care planning. However, we note that there has been a significant improvement in recording ethnicity and that the partnership is aware that further improvement is needed

- **How well are early help arrangements improving outcomes for children and young people, diverting them from care while ensuring they are kept safe?**

We suggest that you accelerate work to develop model of evaluating preventative interventions, based on impact and cost, to inform commissioning.

The peer review team heard that there was still "more to do" to clarify the roles and responsibilities of the newly realigned structure which offers early help and support. It was difficult to ascertain what early help offer was available from partner agencies except for their contribution to Family Connect. We suggest that you look at the impact organisational and process changes have had on demand for some services.

- **Can we be confident that the planned reduction in numbers of children on a child protection plan has been achieved while ensuring children are safe?**

From the case mapping, case records review, audit validation and discussions with social workers, there was no evidence to cause for concern regarding the safety of individual children. Our observations of the systems themselves also gave no cause for concern.

The peer review team heard that the reduction in the number of children on a child protection plans has been achieved by the co-ordination of a number of activities including better practice, introduction of reviews prior to the two-year timescale, data cleansing and changes to conferencing.

- **How well are early support processes, including Family Connect and the triage system, ensuring children and young people receive the right help at the right time whilst ensuring a timely response regarding those in need of protection?**

Family Connect as a single point of contact is reported to work well across most of partnership and experience of triage generally positive. The flow of work and management of demand requires further consideration.

Advice from Family Connect service is reported by school staff to be good. Staff based in the Family Connect service well briefed. There is evidence of it being used as first contact point to signpost into early help services with the nature of those services not yet fully understood by partners.

There is an 'early help' offer understood within the Family Cohesion Service. It is not fully understood across the wider children and family services or by some key partners within the within the Voluntary and Community Sector or schools.

Changes to service delivery within Children's Services have sometimes lead to unforeseen outcomes requiring further changes to services:

The flow and allocation of work would benefit from further analysis and evaluation. Staff in the Children & Family Locality Service (0 to 19) have seen an increase in demand for their service since the implementation of redesigned children services in 2012. This has given rise to some capacity issues and training needs for staff in this area

- **How effective are our social work processes around recruitment, induction, supervision and skills development?**

We commend you on your concerted efforts which has reduced reliance on agency staff and which is providing a stable workforce. The Step Up programme and use of SWIF grant has added to the success of this. Social workers speak positively about supervision and the opportunities for skill development should be enhanced across the workforce with the planned introduction of Systemic Practice.

How effective are the new NHS arrangements in terms of safeguarding?

Arrangements are in place for CCG/health governance reporting: however the current interim arrangements within some areas of the Community Trust provider service are impacting on the Community Trust's ability to deliver effective

services such as CAMHS, SARCS and provide appropriate input into Family Connect.

There is appropriate representation at LSCB of Health agencies. The Health system in Telford and Wrekin has experienced difficulty throughout the recent reorganisation leaving some aspects of service delivery vulnerable with reduced staffing and loss of expertise.

The Public Health service has transferred into the council but the opportunities this brings for integration have yet to be maximised.

Appendix B: Audit Validation Report

Introduction

The audit validation exercise is an optional element of the peer review and aims to examine how the council uses case audit to assess and improve the quality of practice.

Three key issues are explored as part of the exercise:

- a) How effective is the local audit process in assessing the quality of practice?
- b) How well are the audit reports used by managers?
- c) What action is taken in response to the audit reports?

The findings in this report are based on gathering evidence through:

- Meeting with the Service Improvement Manager
- Meeting with the Service Delivery Manager Safeguarding Advisory Service
- Review of 5 case files and their audits
- Follow up conversations with a Team Manager.

1. Local Audit

Telford and Wrekin have a history of using audits to monitor and evaluate case work within children's services, however, it was felt that there was no overarching strategy or consistency in the audit processes and in 2012 a Quality Assurance Framework was developed. The framework has been endorsed by the Children and Families Leadership Team and includes a matrix for Service Managers across children and family services to evidence regular quality assurance activity within their service area.

A quality assurance meeting, chaired by the SDM Safeguarding Advisory Service meets on a 6 weekly basis in order to share outcomes of QA activity and consider how this may impact upon learning and service improvement. This is a very recent development for Telford and Wrekin and the SDM SAS and SIM are open to the challenges of embedding a change in culture towards an audit process that is part of an evolving rolling program of activity and continuous learning.

A key element of the quality assurance framework is the Child Care Case Files Audit Tool (Annex A). This was piloted in April 2013. 28 auditors were identified to work in pairs, including Senior Managers, Service Delivery Managers and Team Managers. 14 cases were selected from the short list of cases that had been identified for the case mapping exercise. The feedback from the audit, including feedback on the process, was reported to the Children and Families Leadership Team on the 7th May 2013. Main themes were extracted with a recommendation that the May audits are completed using the same tool but limited to the sections that related to a specific theme (core assessments). The proposed plan is that whole file audits are undertaken every two months and that themed audits are undertaken on alternate months.

A good case audit template should include the essential elements outlined in the table below. The comments next to each element reflect the extent to which the Telford and Wrekin case audit framework examines these aspects of practice, and how accurate the completed template proved to be in the sample of 5 cases reviewed. In the audit sample offered by Telford and Wrekin, all were completed on paper from information recorded on the electronic Protocol case management

system. Auditors commented that some evidence such as, signatures on documents were difficult to ascertain on Protocol, some questions were unclear and that Protocol could be improved in some areas. Auditors also commented that it was useful to have an audit tool, which enabled the auditor to drill down into an activity.

| Practice Area | Covered by Case Audit template | Comment |
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| Basic Information | Yes | Audits were completed from the information on the referral form. Completion of this section was variable, as some referrals were taken prior to the audit timeframe (6 months) and were therefore not seen as applicable. |
| Effectiveness of current and previous interventions | Yes | Re-referral section (2) of audit captures relevant information. 1 auditor identified learning from first referral. The general comments section at the end of the audit provides a good opportunity for the auditor to reflect on effectiveness of interventions, which aren't captured in the tick, boxes in the main audit. The tool would not identify the contribution of the competence of the worker and the actual intervention itself and how it helped. |
| Assessment of need and analyses – have risk and protective factors been considered? | Yes | The case audit template checks if assessments have been completed. Recording was variable on the electronic case record system which was commented on by auditors. There was evidence of risk and protective factors being considered and auditors noted these appropriately. |
| Service response | Partial | The question is asked whether there is clear analysis and recommendations however, not asked if the recommendations are acted upon. Question re chronologies being in place is asked but whether response has been efficient and timely is not |

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| | | asked although commented upon in general feedback. |
| Effective planning and review. | Yes | All the sections in the audit relating to planning and review seek evidence around child and family involvement in the process and the impact of the plans. These sections of the audit were completed the most fully by the auditors and provided the most information, both qualitative and quantitative. The voice of the child is audited. |
| Building a trusted and effective relationship | Yes | There are questions about the child being seen alone and service user involvement throughout the sections on assessments and plans. Extended family members were included in the case recordings and in the cases audited, all but one demonstrated good working relationships with service users and these were correctly commented on by auditors. |
| A child centred approach including attention to equality and diversity. | Yes | The case audit gives opportunity to state whether the child is seen alone and this is commented upon as well as their views being heard in conferences. Through the audit it was evidenced that a child with a disability may have not had her safeguarding needs fully recognised. This was appropriately followed up. Religion is frequently not completed on the case files and this was commented on by the auditors. |
| Multi agency involvement | Partial | Questions are asked about who contributes to strategy meetings, case conferences etc. Some clear evidence from audits of multi agency involvement but difficult to find evidence of effectiveness. |
| Management | Partial | Whilst the question was asked |

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| supervision and oversight of practice | | about management 'sign off', it was difficult to find signatures on protocol and thus difficult to verify. Supervision records when found on protocol did not demonstrate reflective practice and were task orientated. Again this was picked up by auditors. |
| Quality of case recording | Yes | Clarity of information such as up to date entries, relationships, and key documents such as chronologies are in the audit. Carer assessments were requested. |
| Process monitoring | Partial | There is a section on case file transfers which was completed by one auditor appropriately. |
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The child care case file audit tool for Telford and Wrekin has been piloted for one month and generated a lot of information. The comments sections encouraged comments on the quality of the service with a movement away for a tick box exercise. The feedback and required actions from the first audit were sent through to relevant social workers and team managers and team managers are required to feedback on action taken within 4 weeks. In May the audit will focus on a specific service area and then the management leadership team intend to consider the way forward, including considering a scoring methodology to measure the impact of the audit process.

2. Reports received by management

Reports to management are clearly factored into the Quality Assurance framework and the team was assured that managers at all levels are engaging with the process. It is too soon to evidence a great deal from the recent audit but it is clear that value is put on the audit process and there is a vision that everyone from Directors through to managers and staff, should regularly review a sufficient number of randomly selected cases to maintain a perspective on how well children and young people are safeguarded.

A matrix of collated findings and main themes extracted from the auditors comments in the April audit about issues and good practice and a cross referenced with the quantitative information was presented to the C & F Leadership Team in May.

3. What action is taken in response to audit reports?

It is too soon to say how the audit reports will be used in the future but from the first audit it was evidenced that a manager was keen to ensure a social worker received positive feedback as well as discussing improvements that could be made in practice. Where the audit highlighted the need for more urgent action, this was actioned in a timely manner. The structure for the regular monitoring of casework audits with follow up checks that actions have been completed is in its infancy but there is certainly an

understanding that this is what will happen and an intention that the learning will reach front line managers and practitioners.

Mechanisms for receiving feedback from service users was evident on Protocol but tended not to be completed by practitioners and it is not known if they are aligned to case file audits.

Main messages

Key messages and themes for follow up:

- The new case file audit tool is of good quality and would enable an auditor to consider both quantitative and qualitative information as well as giving the opportunity to consider emerging themes across teams. It is however, very lengthy; 32 pages which 4 pairs of auditors took 3hrs to complete and 3 pairs took 1 – 1.5hrs to complete. Whilst it is understood the ‘themed’ audit will cover less ground further thought could be given to reducing the size of the document. The more quantitative information could perhaps be audited by business support staff and the qualitative by professional staff.
- It was not clear if all social work teams in both Safeguarding and Family and Cohesion Services were using the same audit tool, to ensure consistency across service delivery this should be developed.
- There has been one report for the leadership team and this also commented on the process of the audit. As a first report with an extremely quick turn around it highlighted the themes from the audits and comments on the process. Recommendations need to be SMART. Comments on the audit process from the auditors were presented to the team and were positive about the tool with minor recommendations for change. Comments made re Protocol’s CP template not allowing for analyses of risk and protective factors for child needs to be actioned as do other comments re Protocol.
- To consider a separate supervision audit to capture challenge, reflection and identify risk

Deborah Toni

Appendix C: CASE RECORDS REVIEW REPORT

Introduction

The purpose of the case record review is to afford a more in-depth look at the effectiveness of social work practice by the exploration of a number of case files, discussion with practitioners and managers and a review of some current referrals and assessments during the review week. This report reflects on the findings of the examination of electronic case records and discussions with some of the allocated social workers and their managers.

Methodology

Eight cases for review were selected by the Review Manager from a long list of thirty cases provided by the council. The Reviewer included a further two who were identified as being from minority ethnic communities, as one of the key lines of enquiry the council had identified was how well the racial, cultural and linguistic identity and needs of children were identified and reflected in decision making and care planning. During the on-site week a further six records of cases which had been referred and had an initial assessment during April were reviewed. These cases were chosen at random from a long list provided by the council and, again, due to the key line of enquiry, included two cases identifying an ethnic origin as other than white British.

The cases reviewed in depth included one child currently on a child protection plan, four children in care – two of whom had previously been on protection plan, and four children to whom services were being delivered under child in need plans. One of these had previously been subject to a protection plan as well as having been looked after for a period. One case had recently stepped down from a child in need plan and was being managed by a key (social) worker and a team around the child.

The teams responsible for the cases included the 16+ Team (Transitions Team), the Looked After Children teams, Child Protection team, Assessment and Care Management Team South, the Community Social Work team and the Disabled Children's team and so the cases examined provided a broad representation of practice across the whole of the children's social work service. During the on-site week the

reviewer met individually with several allocated workers/managers and was also able to meet with the remaining allocated workers as a group.

The six case records reviewed during the onsite week had all been processed through the Family Connect Service where the need for an initial assessment had been identified. One case involved a strategy discussion with the Police and a decision that a joint s47 enquiry was needed.

Key Findings

The initial review of case records evidenced that case recording was generally up to date and it was apparent that children were seen regularly by their social workers, and in some cases the case recording clearly identified that children were seen, if not alone, at least without their carer. From some of the recording it seemed that some workers had developed a strong relationship with, and an understanding of the child and their needs. In all of the cases there was evidence of multi-agency liaison and of work being undertaken in conjunction with other professionals.

There was little evidence of management oversight and involvement - in the main this was only apparent in supervision records. However supervision itself did not appear to be consistent, with the reviewer unable to find any record of supervision on nine (56%) of the cases. Those supervision records which were on file tended to be task orientated with no evidence of any reflective discussion having taken place. There was one exception to this where the (only) supervision record on file reflected the discussion that had taken place and the alternatives considered. However conversation with social workers and managers during the on-site week disputed this evidence, as workers were clear that they did receive regular supervision which included the opportunity to reflect but acknowledged that this was not apparent in the written records. The files also did not evidence how key decisions such as permission to accommodate or decision to issue legal proceedings were made. The Review Team were told about the various decision-making forums to which social workers had to present cases in order to progress actions but there was little evidence on the files of the information presented to these meetings, the deliberations or the rationale for the action agreed. There was also no evidence of any audit activity seen on any of the records.

Discussion with allocated workers and managers confirmed that, on the whole, staff had good knowledge of their cases and that they were able to discuss the children's needs and the plans to achieve meeting them with confidence and insight. The Reviewer was reassured about one case which had caused her some anxiety when she had read the case file as she had had some concern that risk was not being thoroughly identified and understood. The manager in this case was clearly aware that the case was a challenging one for the relatively inexperienced allocated worker and was ensuring that she had appropriate support as well as sufficient management oversight. The Reviewer was also concerned about another case where the children had been on child protection plans since March 2010. There was evidence of "drift" and lack of purposeful work having taken place. The discussion with the team manager and - relatively - newly allocated worker demonstrated that there was awareness that the case had not progressed in a timely way and that they had recognised that more robustness in the interventions with the family was needed.

The review of recent referrals and assessments demonstrated a degree of consistency in the application of thresholds for escalating to initial assessment. The cases reviewed also showed that the decision was made in a timely way although there was subsequent delay in the completion of the assessment in some cases. In general, evidence of multi-agency involvement was apparent via the Family Connect processes but not in the assessments. Of concern was that two of the six cases reviewed had only recently been closed – one less than a month previously - and the other in February, the child having been on a protection plan briefly from June to September 2103.

Management information provided to the Review Team identified that the re-referral rate is comparatively high and further analysis is needed to understand the reasons why and to ensure cases are being properly supported once statutory involvement ceases.

The recent referrals also highlighted some data inconsistencies that the reviewer had not noticed when looking at the cases which had been open longer. These inconsistencies included issues such as the box for "NFA" being checked as well as the statement that the case "meets the threshold for private fostering assessment" (the case had been transferred for the assessment to be done) and another assessment had the outcome ticked that the child "was not a child in need" but the decision was that further assessment was needed. Additionally there was evidence of some (generic)

documents being entered on one child in the family's record but not on their siblings'. The case records where there were child protection or child in care involvement - and therefore the recording of statutory visits - had the box checked whether the child was seen or not, and whether this was alone, the equivalent boxes on the initial assessment record was not checked and it was often not apparent from the narrative content of the assessment.

Telford and Wrekin have made obvious efforts to overcome some of the acknowledged problems inherent in ICS compatible systems. Where a child protection plan was written as a Word document - as well as on the system's form - it was easier to understand and responsibilities for the completion of tasks etc. more apparent. One core assessment seen was a "family" assessment with each child's individual needs separately identified but issues affecting the whole family were also clearly noted. However chronologies were not available on the majority of case (75%) and one that had been done was of questionable value as it was a "cut and paste" job with very little evidence of only including significant incidents. There was little evidence of the use of other tools such as genograms, strengths and difficulties questionnaires etc. Some cases (five) did not have a current plan and the child protection plans were not focused on risk and what needed to change to ensure the children were safe.

Two of the four cases involving children from a minority ethnic heritage demonstrated some superficial consideration of the children's cultural need having been taken in to account in the work with the child/family. However staff spoken to expressed lack of confidence in this area of work and were keen to develop more expertise. In general there was little evidence of account being taken religious or spiritual needs.

Areas for development:

It is recognised that the case record review was only able to sample a small number of cases and only a few social workers and managers were spoken to and so it would be inappropriate to make too many generalisations based on it. Nevertheless the following are issues that Telford and Wrekin may wish to give further consideration to:

- A robust procedure for ensuring that supervision records are placed on case records.

- Working with supervising staff to develop an approach to the recording of reflective conversations
- Developing a system for recording informal case discussions
- Agree a format for chronologies that enables them to be a meaningful tool which informs social work practice and are easy to keep up to date
- Understanding the reasons for the high rate of re-referral and satisfy themselves that cases are only closed once the child's situation is sufficiently changed or is being appropriately supported by another agency
- How notes of decisions are placed on case records including the rationale for the decisions made.
- Social workers' request for learning and development opportunities to enhance their knowledge and confidence in addressing issues of cultural diversity.

Jane Scannell

Operational Peer Reviewer

June 2013