

<b>15 December 2010</b>		<b>ITEM 5</b>
<b>Children's Services Overview and Scrutiny Committee</b>		
<b>CHILDREN'S SERVICES SAFEGUARDING PEER REVIEW</b>		
<b>Report of:</b> Barbara Foster Head of Care and Targeted Outcomes		
<b>Wards and communities affected:</b> All	<b>Key Decision:</b> Not applicable	
<b>Accountable Head of Service:</b> Barbara Foster Head of Care and Targeted Outcomes		
<b>Accountable Director:</b> Jo Olsson Director Children Education and Families		
<b>This report is</b> Public		
<b>Purpose of Report:</b> To update Members on the objectives and outcomes of the recent peer review undertaken in September 2010.		

## **EXECUTIVE SUMMARY**

The council and partner agencies commissioned a peer inspection in September 2010, which looked at safeguarding. This report sets out the remit and main findings of the review.

### **1. RECOMMENDATIONS:**

To note the findings of the review and the actions being taken by all safeguarding services in response to those findings.

### **2. INTRODUCTION AND BACKGROUND:**

2.1 The IDeA peer review for safeguarding children aims to help councils and their partners reflect on current provision of safe services for children and young people.

2.2 The review is not an inspection – rather, it is a supportive but challenging approach to assist councils and their partners in celebrating their strengths and identifying their own areas for improvement. The key purpose of the review is to stimulate local discussion about how the council and its partners can become even more effective in delivering improved safe outcomes for children and young people.

- 2.3 During the peer review, members of the review team talked with a cross-section of personnel from the council and its partners, and visited a number of commissioned services. Additionally, a wide range of partners completed a self-evaluation questionnaire, and a smaller group conducted a case file mapping exercise. The review team gathered and analysed the findings from each of these activities, as well as evidence from key local documents and data.
- 2.4 At the end of the review process, the council and partners were presented with the team's findings, during a facilitated conference to support action planning for the future. Within two weeks of the conference, the council received a draft letter setting out the review's findings.
- 2.5 The council is now expected to share the letter with local partners and those involved with the review, but the council can choose whether and how to publish the letter locally. Although the council is under no specific obligation to publish the letter, the Local Authority places the utmost importance on partnership working, engagement and transparency and consequently the findings are being shared with all relevant stakeholders.
- 2.6 The peer review is based on a framework which focuses attention on six "signposts" to good practice. These can be summarised under the following headings:
- Legislation and Policy
  - Leadership, Accountability and Culture
  - Capacity and Capability
  - Effective Practice
  - Performance, Evaluation and Monitoring
  - Local Safeguarding Children Boards and Working Together.

### **3. ISSUES AND/OR OPTIONS:**

#### **3.1 Strengths Which the Review Identified**

- Strong leadership of passionate and committed staff who share vision and energy to build on past investment.
- Evidence of good responses to challenges from the LSCB
- Good learning and development opportunities
- Adherence to firm financial controls and effective supervision of staff
- Commitment to performance management and multi-agency audits
- Some evidence of service user participation
- Good range of services for early intervention and to meet more specific needs, including how our multi-agency groups are well embedded, producing good outcomes for children.
- Commissioning arrangements are being strengthened and the workforce is building in strength and confidence.
- Many examples of effective practice – for example:

- Joint work between the police and children’s social care
- The recent improvement in joint work between the council’s legal and child care teams

**3.2 Areas for Future Consideration:**

- The management of risk across all of the children’s workforce and making sure that everyone is taking responsibility for vulnerable children rather than believing that risk management rests entirely with Children’s Social Care.
- Ensuring quality of services by strengthening and documenting quality assurance systems, including Member scrutiny.
- Reinforcing our partnerships – at both strategic and operational levels and all partners developing the quality assurance together.
- Improving our communications so that policies and news are well known by all who need to know.
- Retaining a positive focus during challenging times and having ambition to move towards excellence.

**Please see letter from Local Government Improvement and Development attached appendix 1**

**3.3 Next Steps**

3.4 The local authority is in the process of reviewing the full recommendations and will be working with partners to draw together an action plan which will address the areas identified as a key priority.

3.5 The first step now that the feedback has been received will be to set up briefing sessions to share the findings with all of our key partners. This will include both those who were involved in the review and those unable to take part as highlighted in the letter. All partners will need to be engaged with a view to drawing up a joint action plan over the next two months.

3.6 The action plan will be targeted, have clear timescales and be reviewed at a senior level.

**4. CONSULTATION (including Overview and Scrutiny, if applicable)**

4.1 The Lead Members for Education and Social Care were both involved in the peer review process and attended the feedback meetings with the Local Government Improvement and Development. Councillor Gaywood was also interviewed as part of the peer review process as part of her role as chair of the Overview and Scrutiny Committee.

## 5. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

### 5.1 Council priorities:

#### Priority 6

Delivering efficient, customer focussed and well designed, well managed, accessible, public services.

### 5.2 Children & Young Peoples Plan

#### Priority 3

Protection when needed - outstanding services for children who may have or may be abused.

## 6. IMPLICATIONS

### 6.1 Financial

Implications verified by: **Yannick Stupples-Whyley**  
Telephone and email: **01375 652532**  
**[ystupples-whyley@thurrock.gov.uk](mailto:ystupples-whyley@thurrock.gov.uk)**

There are no direct financial implications within the report

### 6.2 Legal

Implications verified by: **Lindsey Marks**  
Telephone and email: **01375 652054**  
**[lmarks@thurrock.gov.uk](mailto:lmarks@thurrock.gov.uk)**

There are no legal implications arising from this report

### 6.3 Diversity and Equality

Implications verified by: **Jane Potheary**  
Telephone and email: **01375 652472**  
**[Jpotheary@thurrock.gov.uk](mailto:Jpotheary@thurrock.gov.uk)**

There are no implications for diversity or equality arising from this report.

## 7. CONCLUSION

7.1 To note the findings of the review and recommendations as set out in Section 3 of this report.

**BACKGROUND PAPERS USED IN PREPARING THIS REPORT:**

- Peer Review Guidance 2010

**APPENDIX TO THIS REPORT:**

- Letter from the Peer Review Team

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## Appendix 1

Jo Olsson  
Director of Children's Services  
Thurrock Council  
Civic Offices  
New Road  
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RM17 6SL



29 September 2010

Dear Jo

Thank you for taking part in the Children's Services Safeguarding Peer Review. On behalf of the review team I would like to thank you, your staff and your partners for welcoming us in and engaging in the process. We felt that the people we spoke to were generally aware of the review's purpose and that they took the opportunity to reflect on Children's safeguarding in Thurrock in an open and honest way. The review team were pleased to note a genuine commitment to the safeguarding of children in Thurrock, and found examples of both strong leadership and excellent practice. However, as noted in our final presentation to you, we feel it important to emphasise that peer reviews, like other forms of external scrutiny, are enormously dependent upon the involvement of partner agencies. The absence of involvement from Thurrock schools was a source of regret to the review team. They exercise significant safeguarding responsibilities and our conclusions suffer from their collective absence from the process. In addition, communication with partners in the Health Service prior to the review was inconsistent, leading to some invited participants feeling uncertain as to the purpose of the review or their role in the process. Notwithstanding this, we trust the peer review will still provide you with fresh perspectives and further insights to take forward safeguarding children in Thurrock

We agreed to send you a letter confirming our findings as part of the review process. As you know the review focused on the six key Signposts and the specific areas you asked the team to explore. This letter sets out the overall strengths and areas for consideration the review team identified, together with specific findings for each of the points raised under those headings. It includes the good practice we noted and areas to which you may wish to give further thought. The contents of this letter should be considered alongside the presentation given at the workshop on 10 September 2010 and I have included a copy of this for your information.

It is important to say again that this was not an inspection. The peer team used their experience to reflect on the evidence you and everyone involved in the review process presented to us. The focus of our feedback was on assisting you to both sustain and improve on your current levels of performance towards excellence. It is for you to decide whether this letter is published and how its content is shared with partners and those who took part in the review.

### **Overall strengths**

The review team noted that there is now focussed and strong leadership throughout Children's Services. Following a long period of uncertainty within the authority, there is now a sense of stability, and the drive and direction provided by both the departmental management team and the political leadership is clearly apparent. There is a shared vision and energy for change which has cascaded through to all levels of staff, and to a number of partner agencies. Children's safeguarding is also clearly linked into the priorities of both corporate managerial and political leadership, and the new roles of the Local Safeguarding Children's Board (LSCB) and Children and Young People's Partnership Board (CYPPB) have been well defined and are undoubtedly understood at a strategic level. The authority has a long-term assessment as an "adequate" performer with regard to safeguarding. However, the review team felt that there is evidence to suggest that Thurrock is now in a position to aspire towards a more positive assessment.

Everyone that the team met during the review period appeared to be highly motivated and committed to delivering improvements in their service area. This was coupled with a sound understanding of the new financial controls and the reasons for their implementation. It was encouraging to observe that in some areas, (e.g. the After Care team) officers were regarding the new approach as an opportunity for greater innovation and as a support to the transition to Adult services or independent living. Despite the requirements to focus on cost-reduction, the morale of the workforce in general appeared to be high. There is also an emerging sense of confidence and stability, and the enthusiasm demonstrated by some partners and staff is clearly linked to the energy and vision displayed by those in leadership roles.

The LSCB is well-regarded by the majority of partner agencies. The Police and PCT are clearly committed to the safeguarding agenda and hope that the new structures will deliver better partnership working between member organisations. Safeguarding policies and procedures are shared via the Southend, Essex and Thurrock partnership (the SET procedures). These are currently under review in order to ensure that they are fit for purpose. In addition, the LSCB has demonstrated that it is an active forum for both challenge and issue resolution. Examples such as the challenge provided by the need for faster response regarding paediatric examination in alleged sexual abuse cases demonstrated the robustness with which agencies engage with the board and the determination felt by the board to deliver effective safeguarding.

Feedback that the review team received indicated that training had changed people's practice for the better and was valued by staff who had attended. There was also good learning and development support for social care staff. Regular supervision

processes have recently been introduced and are being monitored. The process for learning from Serious Case Review is well-embedded and the mechanism for dissemination and development of the resulting action plans has been adopted across the partnership and is monitored to ensure its effectiveness. There are also strong local links to local universities, and a number of programmes are being put in place to support on-going learning – for example the Leadership Development programme for the “0-19” team leaders, developed and delivered in partnership with Anglia Ruskin University.

It was encouraging to note that the common assessment framework (CAF) is in use (admittedly to varying extents) across the partnership and that the Essex police are in discussions with the lead officers within the Multi-agency Groups (MAGs) to develop and deliver a training course to support the adoption of the CAF within the force.

There is a clear commitment to develop a robust performance management framework, linked to a basket of locally agreed key performance indicators (KPIs). In addition, the multi-agency case-auditing procedures are established and produce valuable feedback and information relating to quality of practice and performance. A new approach to case audits has recently been introduced at the council, which has returned the responsibility for auditing to the practitioner. This change is to be welcomed as it will encourage greater personal ownership and responsibility for quality. However, it is recognised that the system has not yet fully bedded in, and that an over-arching framework for quality assurance (QA) is not in place.

Performance data is widely available within the partnership and the majority of partners (60% of respondents to the self-evaluation survey) stated that they receive sufficient data to assess performance. In addition, the new IT system is in place in Children’s social care and there is a clear commitment to its on-going development in order to enhance functionality and support effective performance management.

Commissioning is reported to have been has recently been strengthened by the introduction of a jointly funded joint-commissioning team, who have introduced processes to ensure that contract letting and management processes are robust and include criteria linked to safeguarding. An evaluation of all contracts using the SET Section 11 tool is currently underway.

The team found many examples of effective practice – in particular:

- the joint work between the police child abuse investigation team and the children’s social care service
- the recent improvement in joint work between the Council’s legal and children’s social work teams
- the work undertaken by the Multi-Agency Groups (MAGs), which appears to be delivering a practical and successful multi-agency approach to supporting children and families as they come off child protection, whilst retaining the ability to re-refer if escalation becomes necessary.

There are also some good examples of children and young people participating in the decisions made about them and in the on-going development of service policy. Links to the voluntary sector appear to be strong, and there are some areas of emerging good practice developing in some agencies; linked to the changing demographics of Thurrock (e.g. the growing awareness of female genital mutilation and the need to work closely with schools to provide safeguarding support). In addition, the team would like to mention the innovative work of the Therapeutic Foster Care team as a strong example of best practice within Thurrock.

### **Overall areas for further consideration**

As noted above, there are significant areas of good practice and strength with regards to safeguarding children and young people in Thurrock. However, there are a number of issues which we would recommend Thurrock consider in order to both enhance delivery of high quality service and to prepare itself for its forthcoming inspection.

Officers at all levels have a strong and passionate commitment to the safeguarding of children and young people. However, safeguarding is dependent upon a shared understanding and management of risk across the partnership, and all agencies need to fully acknowledge and play their part in this in order to fully discharge their responsibilities to children in need with whom they are in contact. There appears to be a history of lack of adherence to safeguarding thresholds from certain referring agencies, which has caused problems in terms of extremely high referral rates. This has been coupled with a risk-averse culture within the council, which has led to the Council deciding to investigate and assess children where the risk to their safety and welfare is relatively low. This may have resulted in the council picking up safeguarding expenditure that should have been funded by other partners. The current leadership has identified this issue; has put in place financial controls and is seeking to ensure that all partners apply the existing thresholds. However, this has caused uncertainty with partner agencies, and has not always been fully understood by council officers. It is recommended that the approach to the management of risk via the embedding of the CAF and the appointment of lead professionals for children in need and the establishment of “team around the child” meetings to oversee progress of child in need plans should be an approach adopted by the partnership board and communicated and embedded effectively across all partner agencies. This is only likely to be achieved if all partners accept joint responsibility and are fully involved in all decision making.

Effective communication is thus of primary importance if this approach and the new structures are to be successfully implemented in Thurrock. The LCSB will take on a robust scrutiny and review function, whilst strategy determination and operational delivery will fall to the CYPPB. Thurrock hopes that this will provide an appropriate and effective mechanism for delivering the safeguarding of young people, but is dependent upon ensuring buy-in from all strategic partners, including schools. It is recognised that this is an area of both great sensitivity and potential risk as there is a strong and perfectly understandable political desire to ensure that pupil attainment levels increase and members do not wish to see teaching staff taking on

inappropriate child protection duties. However all universal services have an important role in ensuring that children's welfare is promoted and it is generally helpful for those professionals who are already known to children and their parents to seek to address their needs unless there is a safeguarding issue which needs external agency involvement. The review team was told that sometimes referral is made to social care to ensure involvement, but that this often results in social care teams taking a lead responsibility, which should perhaps have remained with the referring partner agency. This suggests a joint training issue in relation to the designated professionals in some partner agencies and the front line management in children's social care. However, it is recognised that all partner agencies must acknowledge and discharge their statutory safeguarding responsibilities, as the council is no longer in a position to deal with referrals that do not meet agreed threshold criteria. It is therefore recognised that the development of a broad and robust joint communications strategy is key to the successful management of risk in order to protect reputation and to ensure clarity and understanding across the partnership and with the public.

As Thurrock does not have co-terminous boundaries with its partner agencies, (e.g. Police, Health, and Probation) it is even more important that there is a common understanding of shared procedures, and it was noted in certain cases (e.g. midwifery) that there appeared to be some confusion. It was therefore felt that Thurrock should ensure that there is clarity regarding understanding of local procedures within the context of regional service policy in order to deliver a consistent service. In addition the statutory position of the Designated Doctor is fragile with the current post-holder intending to stand down. Currently there is no named professional supporting the PCT and independent contracts. While there are plans to review this structure, they were not clear at the time of the peer review.

Although it has previously been stated that multi-agency training has been effective and valued when it has been in place, there is evidence to suggest that not all partners have engaged. There is also a lack of clarity regarding the future multi-agency training programme. It was therefore suggested that the LSCB should evaluate the impact of multi-agency training in order to ensure it continues to deliver a return on investment. It was also noted that safeguarding training is mandatory for staff in social care, but does not form part of general corporate induction for all Thurrock staff. The self-evaluation questionnaire revealed that only 24% of respondents felt that non-specialist staff would know what to do if they encountered a potential safeguarding issue. It is therefore recommended that all staff should be provided with an introduction to safeguarding as part of standard induction training. In addition, although knowledge of and engagement with safeguarding issues appeared to be strong within the Leader and portfolio holders, not all elected members had undertaken safeguarding training. Whilst Lead and Scrutiny Chair members are knowledgeable and committed to their work they are also very recently appointed to their responsibilities and may benefit from specialist training in their respective roles; such training is available through the appropriate LGID Leadership Academy modules. Knowledge and understanding of Children's Services work by senior Members could also be enhanced and updated through an annual programme of 'front-line visits' to service teams; such visits may also be seen by staff as evidence of Member's interest in and commitment towards Children's Services work.

The team also observed that the process for scrutiny of safeguarding – although recently improved - needs to be provided with accurate and relevant information on a regular basis to help ensure robust challenge. It is therefore recommended that Safeguarding training becomes a part of standard induction for all members, and that refresher sessions are held for those who have not received such training for some time. The team also wished to commend the authority for the recent improvement in scrutiny reports and its commitment to effective challenge and review and recommend that the robust scrutiny of safeguarding remains a priority within the Overview and Scrutiny work programme. Complaints often provide a valuable source of feedback from service users and useful information for possible service improvements. It is important that this system is properly monitored, and it is suggested that the outcomes of statutory Stage 2 and 3 complaints are reported annually to Overview and Scrutiny.

Overview and Scrutiny has previously successfully engaged with partner agencies through a review exercise and produced agreed recommendations for action upon an identified priority issue, but there does not appear to have been any subsequent report back to monitor implementation and impact of these recommendations, and it is suggested this should form a routine part of any future reviews. Such an approach may be of assistance in engaging with schools, for example upon the key issue of under-achievement by children from disadvantaged social circumstances, as has been conducted by some local authorities.

Improvement in practice with regards to case audit and QA were observed, but these are not supported by a robust and documented QA process. The review team also noted that although there are examples of effective use of performance data, much of the data-capture and analysis takes place within single agencies and is not shared across the partnership. Given that new structures are now in place, and new arrangements have been made for QA and case audit within the authority, it would appear appropriate to give consideration to the development of a QA framework that can be adopted across the partnership. The development of a performance management framework is also a priority for the partnership, and it is recommended that the CYPPB (in consultation with the LCSB) develop a robust and balanced suite of locally agreed KPIs to support the ongoing evaluation and scrutiny of safeguarding performance.

The review team noted that efforts were increasing to gather and reflect the views of service users; however, more could be done to effectively engage service users and then demonstrate how their views and contributions were impacting on the improvement in service delivery.

### **Key priorities**

The following issues were identified by the authority and partners during the feedback and prioritisation conference on the final day of the review

- Single quality assurance strategy and approach

- Developing the partnership to ensure the new structures deliver effective safeguarding, ensuring that all partners share a common understanding
- The management of risk – via the enforcement of safeguarding thresholds across the partnership – dependant upon a clear and shared understanding of individual partner agencies responsibilities
- The development and implementation of a shared communications strategy – to include all stakeholders – including partner agencies, children and young people, partners and carers.

I hope that the above points are helpful in your drive towards delivering improved safeguarding services for the children and young people of Thurrock I would be happy to discuss further any of the points raised. We would also be grateful for any feedback you and colleagues might have to help us improve the overall process. Thank you again to everyone for their participation.

Yours sincerely



**Paul Curran**

**Head of Safeguarding Programme**

**Local Government Improvement and Development**

**On behalf of the review team**