Jo Davidson
Director of Children's Services
Herefordshire County Council
Plough Lane
Hereford

22nd November 2014

Dear Jo,

Herefordshire County Council
LSCB Diagnostic Pilot

On behalf of the team I would like to thank Herefordshire County Council, partner agencies and the HSCB for commissioning the recent LSCB diagnostic pilot. Your diagnostic was one of five pilots that will inform the January 2015 roll out of the LGA LSCB diagnostic programme.

It is important to emphasise that this was not an inspection but a critical friend diagnostic delivered by a team of peers. The aim was to provide an informed, external perspective on the quality of the LSCB, its key strengths and areas for improvement. The team interviewed key stakeholders, either individually or as part of a focus group, as well as undertaking a comprehensive review of current documentation. At your request two optional elements were added; first, an audit validation exercise focusing on initial plans; second, a review of police engagement and child sexual exploitation processes.

This letter sets out in detail our findings which were initially presented to an invited audience at the conclusion of the diagnostic.

Following an executive summary our findings are set out under the following headings

- Overarching messages
- Working Together Compliance
- Board Effectiveness
- Evidence of Challenge and Holding to Account
- Capacity, Training and Managing Resources
- Vision, Strategy & Leadership
- Audit validation – initial plans
- Child sexual exploitation
- Recommendations

Appendix one provides additional analysis of the audit validation exercise.
We are grateful to Andy Churcher, Caroline Marshall, Chris Jones and Betty Lynch for the efforts they put into preparing for and supporting our visits. The people we met were very welcoming and demonstrated a willingness to use

the diagnostic as an opportunity for learning. We recognise that many of these people made themselves readily available to us at short notice and we thank them for their flexibility.

Executive Summary

You have made considerable progress in the fourteen months since the LGA safeguarding peer review of autumn 2013; there is a renewed confidence within the council and its partners. HSCB is recognising priority areas for improvement and driving learning. The Herefordshire Safeguarding Children Board is clear sighted about the extent of the improvements to reach good and the Intervention Notice still remains. Nevertheless you are now confident in your own ability to manage the future and to take over oversight of improvement from the Improvement Board and driving improvements on the effectiveness of the Herefordshire Safeguarding Children Board itself.

In our view, the key to future Board success is a clear focus on a small number of immediate priorities that drive the work in every element of the Board. At present, priorities are not particularly well co-ordinated across the various levels of activity. The employment of project management techniques will help you to work smarter and achieve demonstrable impact.

There is strong corporate support on improvement, and although needing to become more formalised, you have begun to ensure effective coordination and liaison across key strategic relationships and fora.

You have strengthened challenge, and can point to a number of successful challenges by the Board, such as ensuing the inclusion of the voice of the child within the Children's Partnership Plan and taking on the findings from multi agency audits. There is a greater degree of transparency and openness at the Board and you recognise the scale of improvements that are needed. Whilst there is clear evidence of improvements in performance reporting you know that this has to improve further so that HSCB can maximise its effectiveness.

There is clear evidence that multi agency training and learning from your SCR is having an impact at the frontline. You recognise the need to provide the Board with more effective and better resourced business support and are working with partners to secure sustainable levels of funding to achieve this.

You are aware that in making the effective transition from the Improvement Board, the current pace, depth and relevance of the Board will need to increase. Your improved sense of purpose and focus as a partnership has served you well so far and you are confident of taking Board oversight to the next level and we identified the capability for you to undertake this task effectively.

You have already begun to plan for the transition from the Improvement Board. You need to include in your transition plan risk analysis and

contingency planning. A six month programme of transition support, including coaching and mentoring for key Board members, would help to ensure that the Board maintains sufficient and effective oversight, challenge and pace in the period after the Intervention Notice.

Overarching messages

- **Clarity of role and priorities for HSCB:** We believe that there is a need to clarify and assert the oversight and challenge role of the HSCB, and to focus down on driving a small number of immediate priorities that will continue to enhance improvement of frontline safeguarding. At the moment that which distinguishes the role of the HSCB from the Improvement Board, and other fora such as the Children's Partnership and Community Safety Partnership is not clear to everyone. HSCB activity is not coordinated on a small number of key priorities that drive the strategic board, the steering group and your sub groups.
- **Take the initiative on improvement:** You have been under the spotlight in terms of improvement but we saw a renewed confidence that you can manage this process yourselves; and a willingness to take the sometimes difficult decisions that will inevitably be necessary
- **Reactive to proactive:** We feel that you need to move from reacting to external critique and inspection to a proactive approach based upon forthright self assessment, where you use your own self knowledge, constantly re-evaluated, to identify and act on areas for improvement
- **Process to outcomes:** At the moment you are too process focused, the aim of structures is to achieve measurable outcomes for children; processes will only take you so far and the Board needs to concentrate on what will achieve measurable improvement in practice against key outcomes and keep reporting this
- **Do less but focus:** You are spreading your resources across many areas, we suggest that you do less but focus your attention upon circa six key priorities that link across the work of the strategic board, the steering group and your subgroups, that way you can begin to show impact
- **Network network network:** You are open to external learning opportunities and continuing to make the most of the support and new ideas that these bring is essential, and this is having an impact; as you take over from the Improvement Board you will continue to need the support and guidance these networks give you as a sounding board and to provide coaching and mentoring
- **Beg borrow and steal:** You can save yourself time and energy by using the success of others wisely; do not be afraid to beg, borrow and steal ideas to save developing your own solutions to everything
- **It's about the big picture not just ticking the box on documents:** We have seen that sometimes completing a task is equated with achieving improvement; for example in May 2014 HSCB completed a self assessment but this does not appear to be updated or re-evaluated to reflect whether/how the Board has progressed. By consistently revisiting the findings and using the self assessment as a living document that you self evaluate against at subsequent meetings you will improve its value in supporting improvement. The value of a self assessment, or QA report findings, or challenge to an agency on lack of progress, lies solely in what you do with it on an ongoing basis to ensure something of value occurs on the back of the original action.

Working together compliance

Strengths

- You have renewed and reinvigorated your local threshold document; this has been widely disseminated and is helping to drive improvement in frontline practice. Staff value the document you have produced

- The SCR and Child Death Review arrangements are working well and we were impressed by the quality of the people we interviewed. The case review decision process referral form is effective and there are clear escalation processes. Staff could readily refer to learning from the HH SCR

- You have recognised the need to improve the functioning of the safeguarding board and have held a number of successful development events. We thought that the joint meeting with the Children's Partnership was a very productive initiative, and heard reports that the CSE event was very useful

- Your statutory core membership is compliant with regulations

- The proposed induction arrangements and training/mentoring for Board members is a very positive step forward to maximise effective participation in the work of the Board and we also welcome the training initiative to improve councillor awareness of safeguarding

- The buddy system to embed challenge in the way you undertake Section 11 audits is a very positive improvement

Areas requiring improvement

- Although there is an established protocol between the Health and Wellbeing Board and HSCB, this needs to be strengthened and brought up to date and include the Adults Safeguarding Board, the Children's Partnership and the Community Safety Partnership; terms of reference do not yet effectively delineate these key strategic relationships

- You undertook Section 11 audits in 2013 to hold partners to account and drive improvement but the impact of these has been diluted by not being able to evidence effective follow up. At that time, some agencies didn't have clear statement of responsibility towards children, and a number of agencies reported that safeguarding needs to be a standing item at senior management meetings. The discrepancy between your own section11 findings and the recent CQC inspection of Wye Valley Trust need to be investigated to ensure that all Section 11 audits are undertaken with the necessary rigour in the future and that the Board follows up progress assiduously.

- Your S175 (maintained schools) and S157 (independent and academy schools) analysis needs to be carried out and any learning fed back; this process could help to strengthen the role of schools and academies on HSCB

- You have some well established working relationships with the education sector, and board representation - 'they are part of the family' - but equally acknowledge that this is a work in progress that warrants improved engagement and communication to move beyond those 'already signed up' as well as including the early years sector

- We recognise that your learning and improvement framework is at an early stage of development. A more joined up and cohesive learning and improvement framework will help you to better understand the safeguarding system; especially if informed by service user feedback. HSCB attendance logs should be maintained and regularly reviewed to ensure reach is maximised

- You could use the Annual Report more smartly to explore vulnerable groups of children, to identify priority areas of business and to influence planning and commissioning linked to Children's Integrated Needs Assessment which will also reinforce a single plan. An improved focus in the annual report on performance reporting linked to key priorities and thematic audits is needed. At the moment audit is effective in what it sets out to do but is limited in impact on improvement because of the focus on remedial action to address individual learning from cases. Audit - and Board performance monitoring - needs to be thematic not case reactive

- You have recognised the need to update procedures and these are part of your improvement plan, but in order for the HSCB to have an effective grip and control we think you should review the three year timeframe on this. HSCB will also need to endorse the Local Authority assessment framework as per Paragraph 62 (Chapter1) of Working Together 2013

- In Working Together 2013 early help is a key feature. This was not within our remit for the diagnostic so we are unable to form a view on this.

Board effectiveness

Strengths

- Good will, ambition, willingness to work together

- Drive and ambition within the sub groups, the strategic board and the steering group

- Intent to create structure to achieve coordination across the Community Safety Partnership, Children's Partnership and Health and Wellbeing Board

- Case review learning processes involving front line practitioners provide a line of sight to the frontline

- QA process

- Delivery of training strategy based on needs analysis

Areas requiring improvement

- Pause and take time to know yourself. You have had to undertake a very considerable improvement journey. We think now is the time to take stock of where you are, identify what you do well, and where you have to be more effective, and focus on getting it right all the time. That will make you an effective forum for challenge and oversight, a function that will be all the more important if the Intervention Notice is shortly to be lifted

- Learn to trust your own judgement. You are very used to receiving external definitions of your areas for development, and have used those judgements well to drive improvement. To achieve your own ambition of 'good by 2016' you will have to become an effective learning organisation that consistently is self aware on both success and failure and continuously monitors its own working arrangements and progress on key goals. At the moment you are beginning this process and your May 2014 self assessment provides the basis for stepping up to the challenge if it is used smartly to regularly reassess how you are performing. A simple review of progress against the self assessment would be a useful way to conclude board meetings and could be incorporated as a standing final item on the agenda, focussing on a small set of easily understandable questions such as how much have we done to address deficits and improve our own working as well as frontline practice, how well have we done it, and what difference have we made today against each of our priorities?

- One plan to take you forward, focus on making a difference. You are all working hard on many fronts but need to focus all that activity upon what is most important At present the HSCB does not have a small and consistent set of key priorities that inform its work from strategic board to sub groups, nor do other strategic plans yet align fully across with your own. Success will only come with a consistent focus for your and others' activities on those small number of factors that will make a difference now, that the HSCB monitors regularly and challenges when necessary. A golden thread needs to link across all strategic fora and within the HSCB from the strategic board down through the steering

group to each and every sub group; all need to share the same work programme with their own work stream clearly linked to the overarching priorities and feeding into to them

- Project management. The Children of Herefordshire Improvement Partnership Programme has proved that you have effective project managers within the partnership. Use this expertise to improve rigour and robustness within the Board. Using a project management approach, and a smaller but clearly delineated set of common priorities, will help to improve rigour and robustness of performance monitoring and subsequent holding to account for under performance

- Pace up. You are ambitious to take over from the Improvement Board their responsibilities. This will require increased responsibility and oversight by HSCB to ensure the pace of improvement is maintained. You are planning how you will achieve this increase in responsibility and oversight at the next HSCB meeting. This meeting provides a good opportunity to start to employ a project management approach to plan for and take through to conclusion this transition. You are aware that you may need to put in place transitional arrangements and support/mentoring and are investigating who is best placed to provide this. It is equally important that you develop a risk register, for the wider improvement journey, as well as for the transition to taking over from the improvement board and use this to move forward effectively; and contingency plan to minimise deficit and failure. Key questions to take you forward include; do you know where you are in getting to good? Are you clear what taking on the scrutiny role post the Improvement Board actually means in practice for the HSCB? What are the risks and what is needed to be put in place to secure this role for the HSCB going forward?

- Where does the real power lie and how does this impact on wider engagement? We heard the steering group described as the engine room but this group is chaired by the Assistant Director, Children's Safeguarding and Family Support and not by the HSCB Independent Chair. If this is the engine room we feel it should be chaired by the Independent Chair; and if indeed it is to continue as the engine room, what implications does this have for the strategic board, is the strategic board to become just a rubber stamp for the steering group, and, if so, how will that impact on engagement and ownership of improvement across the wider partnership on that strategic board? The messages given out by how your structure is actually perceived to work in practice will influence how well engaged all partners are with the Board

- You have good police attendance at the Board but the current arrangements put in place by the merged police forces (the strategic alliance) may not best serve the Board; we think this is an issue that needs to be raised on a pan regional basis and would advise that this is taken forward in conjunction with your neighbouring Boards through the

developing arrangements in which the Chair of the HSCB and the DCS are engaged.

- The voice of the child, and family, is not very well developed at Board level. You acknowledge this and are planning to address this in the near future. The views of young people and families can inform HSCB business priorities and provide effective challenge on improvement through user feedback

Evidence of challenge and holding to account

Strengths

- The HSCB now operates with a stronger degree of challenge. There is more honest discussion of for example the deficits revealed by the case audits and the need for the partnership as a whole to work smarter. We were told that there is now much greater transparency in partnership discussions when it is identified that things have gone wrong

- The two recently appointed lay members are reported to add significant value to the work of the Board and to have enhanced challenge within Board meetings

- HSCB can be proud of a number of 'challenge successes'. These include taking on the findings from the programme of multi agency audits, challenging the Children's Partnership to include the voice of the child within the children's partnership plan, and negotiating for the Children's Integrated Needs Analysis to supplement for the lack of a children's safeguarding focus within the JSNA

- Case specific escalation via the QA sub group has been very effective in raising case specific deficits at Board level and is a good first step to a successful QA sub group

- There is widespread recognition of the need to produce a data set that is fit for purpose and work is ongoing to achieve this linked to the ongoing transformation programme for the Frameworki computer system in social care

Areas requiring improvement

- Increase in data quality and evidence of impact. You are working to improve data quality but the focus is on producing better quality and fit for purpose quantitative data. A positive enhancement of the data set would be to include qualitative measures, including user and family feedback. This has begun with the most recent feedback from families and professionals on the effectiveness of child protection conferences.

- HSCB should prioritise establishing a set of indicators against each Board priority and have these set out in regularly updated performance scorecards. This would help to give assurance to the Board that frontline practice improvements were being embedded and sustained.

- A strengthened QA sub group is needed to drive development. The QA subgroup is very active and has raised many useful issues but at heart it is reactive to the deficits of individual cases. The sub group needs to move to looking at findings from individual cases as a pointer to wider thematic issues that hold back improvement and move from individual case review to thematic practice based audit. The group meets monthly but only four multi agency audits were undertaken last year. A more focused and productive work programme needs to be developed that will feed in to the newly revised key priorities of the Board

- Much smarter QA reporting would provide the Board with the information it needs to challenge on its priorities. HSCB is already aware of a number of potential thematic and practice focussed issues e.g. the waiting times for CAMHs and the Speech and Language Service. Currently, although well known practice issues, there has been little escalation or challenge via HSCB on either of these. There is potential here for the QA subgroup to focus on these areas as an exemplar of future working practices which will also enable the Board to drive improvement across the multi-agency partnership.

Capacity training and managing resources

Strengths

- You have recognised that you need to increase capacity of the business unit, and that synergies can be obtained by coordinating business support across other fora. A plan is in place to enhance business support and negotiate a sustainable multi agency funding stream

- We saw evidence of an effective training cycle in operation, one recent good example of which was the development and commissioning of DV training on the back of this being flagged as an issue in the staff survey

- We heard lots of positive feedback on the training and development events delivered by the Board and you looking at implementing evaluation of impact

- Learning from the HH SCR was evidenced in our discussions with frontline staff

Areas requiring improvement

- In the post Improvement Board world HSCB will have to work much smarter. One obvious example is in the regular use of performance management techniques to drive forward improvement. This can be brought in e.g. by consulting with colleagues who have employed this successfully within the Children of Herefordshire Improvement Partnership Programme.

- You are planning to look at how you put in transition arrangements to support the Board in the immediate period following the lifting of the Intervention Notice and to do this successfully you need to undertake risk analysis, contingency plan and put in place the kind of transitional leadership support that we set out below

- You need to secure the future funding across partner agencies for a strengthened business unit as without that the work of HSCB will be compromised. The business unit is not resourced effectively at the present time and struggles to provide the high standard that it sets itself in terms of support to the two safeguarding Boards

- It would be useful to set out clearly what the next year will look like in terms of the Board. What does a 3, 6, 12 month trajectory on HSCB improvement look like? What are the milestones that you need to see and the actions necessary to achieve the step change in oversight that HSCB is aiming for, and how will you report on and know you are making progress? Setting these out clearly and simply and agreeing them with the whole partnership will start to make your work more outcome focused and provide focus for the work of the various sub groups. It will help to identify skill deficits within the Board so these can be addressed in a systematic and timely way

- There is a wider capacity issue that HSCB needs to address, namely capacity and fitness for purpose of the children's workforce in the widest sense. We have mentioned above access to specialist services such as CAMHS and Speech and Language Services but there are other capacity issues where the board needs to secure improvement e.g. management oversight and decision making as well as stability of the children's workforce. These require analysis, holding to account and challenge at Board level. Again these provide a good starting point for effective project management of key issues and priorities and are examples of the work which the Safeguarding Children Board will be taking over from the Improvement Board.

Vision strategy and leadership

Strengths

- Excellent progress has been made since the peer review 14 months ago, and there is coordinated and effective working with key players to identify improvement targets and to address deficits

- You are ambitious and are committed to achieving the improvements necessary to have articulated what 'good' is in Herefordshire, and be judged 'good' by Ofsted by 2016/17

- There is strong cross party political commitment to the safeguarding agenda, and a clear prioritisation of the children's agenda within HCC

- We saw a strong commitment to corporate parenting which is to be strengthened by mandatory councillor training which will continue after the 2015 elections

- The detailed analysis of need provided by the new Children's Integrated Needs Assessment will help to focus attention on achieving improved outcomes

- You are working well to address local and regional CSE issues

- The HSCB Chair has regular meetings with the Chief Executive, the Director of Children's Services, the Portfolio Holder and the Police and Crime Commissioner

Areas requiring improvement

- You are aware you need to increase the current pace depth and relevance of the Board to secure the handover from the Improvement Board of their responsibilities – we would advice a programme of coaching and mentoring for key players to maintain progress in what could be a risky period.

- You need a simplified and coordinated shared vision of the safeguarding priorities that drives the work of the partnership and informs the challenge function of the Board. This should include continued work to achieve and maintain the culture shift that safeguarding is not just a local authority responsibility

- You need an HSCB identity, and for the HSCB to become more influential and visible

- Simple clear roles and priorities for the HSCB would help to define its true purpose – you need to avoid the current blurring of Board roles, to help you to distinguish between what is HSCB and what is Children's Services

- If you continue with this structure we are strongly of the belief that the Independent Chair should chair and drive the steering group. This will enable the Independent Chair to have increased oversight of the work being taken forward in the sub groups and to ensure that the work of the sub groups reflects and aligns with HSCB priorities

- We were not convinced that there is clarity, discussed and agreed across the partnership, on the role and remit of the steering group, nor its relationship to the strategic board. There is a fundamental question to answer here, namely where do you want your power house to be, and who do you want to lead it? At the moment this is unclear to us, and this lack of clarity may well be shared with others

- Current MASH governance via a HSCB sub group is an example of the blurred roles we discuss above. We know why you chose this arrangement initially; nevertheless this is an operational delivery function and with the MASH reinvigorated do you still need governance via HSCB?

- Capture and gather the voice of the child and feedback from families– the voice of children and families should be at the heart of everything HSCB does and a major influence on how HSCB pushes for change

- Police regularly attend the Board meetings; however, we do believe that it would be worth exploring with your police representatives firstly, how police plans interact across the Protecting Vulnerable People Plan, the local delivery plan and the CSE strategy to deliver better safeguarding outcomes and, secondly, whether current arrangements for Board representation by the Police deliver local knowledge and focus

- We feel that current arrangements for meetings between the Independent Chair and key senior managers, politicians and stakeholders should be formalised with a clear, set agenda that includes performance reporting and holding to account through the Annual Report

Audit validation - commentary on the findings of four cases

The audit validation was bespoke and focused on a safeguarding system approach to child protection planning and working together, to achieve improved outcomes.

Strengths

- Staff were engaged and appeared to communicate with each other

- Staff were aware that practice needs to improve in order to improve outcomes for children subject to Child Protection Plans

- Staff acknowledge a range of issues that currently impact on performance e.g. turnover of staff

- Staff welcome further training to improve practice; they were reflective in the focus groups and would welcome more time for case reflection

Areas requiring improvement

- Plans were not robust – neither SMART nor linked to outcomes
- We saw a lack of contingency planning
- Expectations on parents were not made clear
- Managers did not consistently attend conferences and core groups. Effective management oversight is key to ensuring progression of Child Protection Plans
- There was some evidence of drift in both assessment and intervention; a major cause of this was the high number of changes of social worker
- We saw numerous changes in social worker between conferences
- The parenting assessments we saw were neither robust nor timely
- There was a lack of escalation from all partner agencies when progress was not made on plans by any agency
- Decision making wasn't clearly recorded with the rationale and the risk management clearly set
- Multi agency training on conferencing needs further developing

CSE

- You have put in place a strategy and action plan, there is a reinvigorated structure, a specialist CSE unit has been established, there is currently a new specialist social worker in this unit, to be joined by a police post in the next financial year
- The new strategy complies with national recommendation and is based on national guidelines
- The action plan is a positive step forward, however, it has numerous actions but no real outcomes. It is lengthy, and there is a real need to prioritise the priorities! With so many outcomes it is unrealistic for them all to be completed. A focus on a smaller number of key priorities in the immediate term is needed, with consideration of how additional priorities can be rolled out over time. As yet the action plan has not been effectively disseminated

- The new CSE team (that was only in place during the week of our visit) have been very quick off the mark and reports from other frontline staff are positive, which is very impressive for such a new development. There is the potential that demand will swamp this new provision so there is a need for tightly controlled and managed referrals to the unit

- The police are committed to increase their involvement and resources over the coming twelve to twenty four months

- The Board structure is now clear with a CSE group and an operational group below this

Recommendations

You might wish to consider the following recommendations. These are based on what the team has read, seen and heard over the course of the LSCB diagnostic.

- Identify a small number of HSCB priorities aligned across other strategic fora - and stick with them, when refining your priorities decide which are immediate priorities to be put in place now and what are aspirations for the longer term

- Fund and implement a reinvigorated and fit for purpose business unit

- Review the Board structure in the light of your priorities and statutory requirements and streamline the steering group and make this a chair of chairs group

- Make sure all members of the strategic board are fully engaged and understand their relationship between being on the Board, improving agency practice and achieving impact on outcomes for children

- Make all agencies accountable for what they have committed to at the Board

- Locate MASH governance within Children's Services operational management structure

- Use formal challenge by HSCB to other agencies to escalate concerns revealed through audit and feedback from the staff and families

- Evidence impact of HSCB challenge and the better outcomes that HSCB has achieved

- Project manage everything especially the transition from the Improvement Board

- You are seeking tangible improvement in children's lives and need an outcome focus to ensure that what you do achieves this

- User voice will give the Board confidence and understanding of what has and has not made an impact

Throughout this letter we have sought to outline the strengths of the LSCB arrangements in Herefordshire, along with areas for consideration and improvement. You and your colleagues will no doubt now wish to reflect on the team's findings and consider how our findings might inform future plans and activities.

For further improvement support you can contact the LGA's Principal Adviser for the West Midlands region, Howard Davis, who can be contacted via howard.davis@local.gov.uk or on 07920 006 1971 . In addition, you can contact Claire Burgess, LGA Children's Improvement Adviser covering the South West Region for specialist support. Claire can be contacted via claire.burgess23@gmail.com or on 07854 407337.

Once again, thank you for participating in the LSCB pilot diagnostic and please pass on our gratitude to everyone involved.

Yours sincerely

Peter Rentell
Programme Manager (Children's Services)
Local Government Association

Appendices:

Appendix 1 - Audit validation - initial plans

Appendix 1 – Audit validation initial plans

LGA LSCB pilot diagnostic Herefordshire County Council
LGA peer: Jonathan Williams
Date: 17-19 November 2014

Audit validation – initial plans - summary

Five cases were looked at; four of these involved meeting with a focus group and two of these involved the inclusion of a parent. The fifth case was linked to the observation of a CP conference. It was unfortunate that the conference could not be observed because the parent did not consent. A telephone conversation later took place with the CP chair.

Notes about the individual cases are outlined below

Strengths

- Staff were engaged and appeared to communicate with each other
- Staff were aware that practice needs to improve in order to improve outcomes for children subject to CP Plans
- Staff acknowledge a range of issues that currently impact on performance e.g. turnover of staff
- Staff would welcome training to improve practice; they were reflective in the focus groups and would welcome more time for case reflection

Areas requiring improvement

- Plans were not robust – neither SMART nor linked to outcomes
- We saw a lack of contingency planning
- Expectations on parents were not made clear
- Managers did not consistently attend conferences and core groups. Effective management oversight is key to ensuring progression of CP plans
- There was drift in both assessment and intervention
- We saw numerous changes in social worker between ICPC and RCPC
- Parenting assessments were neither robust nor timely
- There was a lack of escalation from all partner agencies when progress was not made on plans
- Some decisions made could have made children vulnerable and left organisations at risk
- Multi agency training on conferencing needs developing

It would appear that the main focus of improving plans has been linked to the redesign of Framework I and the reformatting of the iitial plan layout. Only one of the cases had this plan in place as it had only been introduced in the last two weeks; the plan did look better.

However a systems approach to approving plans may be required.in addition to the newly introduced format; this would entail for instance asking the following questions from a multi-agency perspective - how much have we done, how well have we done it and has it made a difference?

During the audit validation we saw a number of issues that impacted on effective planning

- Changes of social worker (one case had four changes of social worker in the period from assessment to first review);
- Lack of risk analysis (often there were blanket risk statements, eg mother smokes cannabis. It did not state how much, when, frequency, storage, whether the child was present etc. – there was little connection with the impact on the child);
- Poor management oversight (little evidence of managers attending CP conferences or core groups) – is this linked to capacity, managing high caseloads and frequent changes of staff? Managers from focus groups seemed engaged, intelligent, insightful and reflective with a genuine aim of improving outcomes for children. Therefore wider issues need to be explored
- Ineffective plans. It is the role of the Chair to steer, facilitate and provide guidance and leadership. However partner agencies need to own the plan and contribute to it at conference. There is a lack of training and direction in relation to the model of conference. There are snippets of strengthening families being used but this is only by Social Care. The LSCB could take a view on what model needs to be taken forward and develop it accordingly, including the commissioning of training.
- All participants need to be responsible for escalation of issues, especially when there is drift on case because of agencies' ineffectiveness to provide a service. The two parents who attended the ICPC's were not given copies of the complaint procedure in relation to agencies where progression of the case was being hindered because of agency engagement. In addition, agencies did not escalate when there were changes in social workers, when actions were not completed, when services were not being delivered; this is not solely an issue for social care and the chair.

A number of key questions arise from the audit validation in relation to oversight by the LSCB.

First is a series of questions in relation to oversight of performance and practice

- The LSCB could use the above analysis as a starting point to investigate how far what has emerged from our findings is leading to an increase in CP plans

- Are the issues raised in the audit validation exercise currently being measured by the LSCB, and, if so, in what way do you need to amend or improve oversight, and, if not, how is the LSCB to investigate further the findings of the audit validation exercise?

- Is the current method of scrutiny of the LSCB data set and associated quality assurance activity via the sub group fit for purpose so as to reassure the Board that front line practice is – and will continue to be - safe and effective?

Second how the work of the LSCB links with improving front line practice

With regards to the front line staff's view of the LSCB, staff from focus groups demonstrated the following

- Learning from the recent SCR HH – staff understood the issues. There was some query about delay of the Framework I LAC notification being put on the system.
- Good training for multi-agency staff at operational level including learning from the HH SCR e.g. CSE, Framework I and Domestic Abuse.
- Training is not as relevant for middle and senior managers
- The threshold document is understood by partner agencies
- Referral pathways have improved, especially since there have been developments in the MASH