APPENDIX 4

SOUTHEND TOGETHER
INTERNAL AUDIT WORKING GROUP
SUMMARY REPORT

LOCAL SAFEGUARDING CHILDREN BOARD
SERIOUS CASE REVIEWS

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RESOURCED BY:
SOUTHEND-ON-SEA BOROUGH COUNCIL
NHS SOUTH EAST ESSEX
SOUTH ESSEX PARTNERSHIP FOUNDATION NHS TRUST (SEPT)
ESSEX PROBATION SERVICE
SOUTH ESSEX HOMES

LOCAL CHILDREN'S SAFEGUARDING BOARD
SERIOUS CASE REVIEWS

OBJECTIVE

To assess whether the Local Safeguarding Children Board (LSCB) and partner agencies have robust arrangements in place to effectively implement the lessons learnt from serious case reviews to improve the overall future protection of children in Southend.

SCOPE OF THE WORK

LOCAL SAFEGUARDING CHILDREN BOARD

The structure of the LSCB including the various groups that report to it and how it reports into Southend Together is attached at Appendix A.

The review assessed the adequacy of arrangements in place:

- to monitor the implementation of recommendations made by the Case Review Panel; and
- for reporting progress on implementing the recommendations to the LSCB's Executive Group and the main LSCB.

PARTNER AGENCIES

For recommendations identified from Serious Case Reviews

The review assessed the adequacy of arrangements in place to make sure that:

- where process improvements needed to be made these were clearly communicated and understood by staff;
- there was clear officer accountability for addressing the actions; and
- there were procedures in place to monitor the implementation of recommendations made.

The review tested that the recommendations made in the Baby R case had been properly implemented. This case was used to test whether the arrangements at an organisational and partnership level were good enough to ensure that any required actions were undertaken properly and in a timely manner.

The partner organisations involved in this case, with recommendations in the resulting action plan were:

- NHS South East Essex;
- South Essex Partnership Foundation NHS Trust (SEPT);
- Southend University Hospital NHS Foundation Trust (the Foundation Trust);

- Southend-on-Sea Borough Council (SBC), Department of Children and Learning;
- SBC Adult and Community Services (Housing Services) ;
- Essex Probation Service; and
- South Essex Homes.

AUDIT APPROACH

The cross partner Child Protection Procedures (2006) covering Southend, Essex and Thurrock (SET Guidance) specifically acknowledges that "as much effort should be expended on acting upon recommendations as on conducting the review" (Serious Case Reviews - Section 14 Strategic Management – Learning Lessons Locally).

As such, the commissioning of Southend Together's Internal Audit Working Group (IAWG) to review the cross partner processes in this area demonstrates a real commitment to this principle by the LSCB. In doing this, it has obtained independent assurance that:

- lessons learnt from serious case reviews are built into partners day to day operations; and
- overall, safeguarding practice regarding vulnerable children is improved.

This report summarises the findings of the IAWG for six of the seven partners originally involved with the serious case review (SCR) of Baby R. The flexible approach adopted by the partners to incorporate this work within previously agreed internal audit work plans is much appreciated.

Unfortunately Southend University Hospital NHS Foundation Trust was the only partner not to be able to contribute to this review. As such it is not possible to give any assurance over the robustness of arrangements within this organisation.

In view of the potential risks involved, it is recommended that the LSCB require the Foundation Trust to separately provide the required audit assurance.

SUMMARY FINDINGS

MONITORING IMPLEMENTATION OF RECOMMENDATIONS

LSCB MONITORING ARRANGEMENTS

Arrangements are in place to monitor the implementation of recommendations. Partners are regularly asked to provide the Case Review Panel with reports on progress made in addressing the issues raised. In addition:

- overall progress is reported to the Executive Group; and
- a performance indicator for the percentage of recommendations implemented, is reported quarterly to the main LSCB.

However, inconsistencies in these arrangements were noted in that:

- not all partners provided evidence to the Case Review Panel to show that recommendations had actually been implemented;
- it was not possible to systematically track progress through the minutes of the Case Review Panel, of the implementation and final sign off of the recommendations; and
- there is some confusion over when the allocation of the Red / Amber / Green (RAG) status assigned to recommendations is changed and who currently undertakes this. Some agencies consider this is assessed and changed by the LSCB Business Manager and some alter the status themselves, based on their own assessment of progress made.

There is therefore scope to improve these arrangements by:

- formally defining them, ensuring they include the LSCB's expectations of the evidence required to be seen before recommendations will be signed off;
- developing the function of the Case Review Panel in reviewing and challenging evidence presented to support that recommendations have been addressed;
- assigning the Case Review Panel the role of updating the RAG status when it is satisfied of progress made; and
- requiring there to be better evidence of discussions and decisions made by the Case Review Panel via the minutes of meetings.

The Executive Group has specifically monitored some recommendations considered to be "high risk" where delay or failure to implement has the potential to significantly impact the safety of children. However:

- the monitoring of high level risks / high priority actions is not a fully integrated part of the Executive Group's assurance arrangements; and

- there is no defined approach to assess the risk regarding issues identified or priority attached to recommendations made.

Addressing both of these issues would significantly strengthen the overall monitoring arrangements and therefore the assurance available to all that properly focused challenge is being consistently applied to recommendations.

PARTNERS' MONITORING ARRANGEMENTS

The evidence available to confirm partners' arrangements regarding accountability, communication and reporting in relation to implementing recommendations contained in action plans was mixed i.e.:

- With all six partners there was clear officer accountability for addressing actions to improve processes.

- Partners were able to describe the arrangements for communicating required improvements to their staff and teams and four of the six were able to provide evidence or external assurance of this (i.e. SEPT, NHS South East Essex, South Essex Homes and SBC's Department of Children and Learning).

  Opportunities to improve the capture of these actions through for example minutes of team meetings were identified within the Essex Probation Service and SBC's Housing Services.

- Evidence to confirm the formal governance arrangements in place for reporting progress on the implementation of recommendations up through the various management levels was provided by four of the six partners. For SBC's Department of Adult and Community Services (Housing Services) arrangements have been drawn up, but require final agreement by its Corporate Management Team. South Essex Homes still need to develop formal reporting arrangements and incorporate these into their Safeguarding Children and Young People Policy and Procedure.

  Opportunities exist to improve the manner in which monitoring implementation is recorded at lower operational levels within three partners i.e. SBC Departments of Children and Learning and Adult and Community Services and the Essex Probation Service.

Action plans with agreed implementation dates are being drawn up by partner internal audit teams where opportunities to improve arrangements have been identified. It is intended that partner internal audit teams will monitor implementation of the recommendations and report progress to their respective audit committees and the LSCB.

IMPLEMENTATION OF ACTIONS CONTAINED IN PARTNERS' ACTION PLANS

It has not been possible to obtain sufficient evidence to confirm that all the required actions detailed in action plans have been addressed. A separate report has been produced for the Case Review Panel summarising the status of all recommendations arising from the serious case review following the audit. It highlights where and what further evidence is required before the Case Review Panel can sign off recommendations. To gain independent assurance that actions have been fully implemented the LSCB should require that partner internal audit teams review the evidence supplied and formally confirm to the LSCB that recommendations have been addressed. Internal audit teams regularly follow up and evidence the implementation of audit recommendations so this could be easily incorporated within current processes. The more detailed arrangements of how this can be achieved for the LSCB will be discussed with the LSCB Business Manager.

Identifying the evidence that was required to confirm implementation of individual actions was generally clear. However, there is still scope for improvement in this area. It is critical there is absolute clarity about all the actions required to mitigate any potential systems weaknesses when dealing with vulnerable children e.g. where policies / procedures are developed or changed the next logical action would be for the staff to be briefed on the changes / new policy. This in itself increases the likelihood that the action will be implemented and makes it easier to monitor delivery effectively.

If a future SCR arises SBC's Internal Audit team would be willing to work with the LSCB to support the process of developing action plans emanating from Individual Management Reviews.

The successful implementation of SCR recommendations is key to improving the safety of children. As such it is recommended that the LSCB, as part of its assurance framework, requires all partners to follow up the implementation of the recommendations, as they become due, in their routine follow up arrangements (see above). Again the more detailed arrangements of how this can be achieved for the LSCB will be discussed with the LSCB Business Manager. Establishing a formalised approach will give assurance that partners' internal auditors are adopting a consistent methodology regarding this work i.e.:

- documentary evidence is obtained of each action required to implement the overall recommendation; and

- where actions require changes / and or the development of new procedures, the recommendation is highlighted for further follow up visits to confirm the practice has been embedded within day to day operations.

CONTRIBUTION TO SOUTHEND TOGETHER'S AMBITIONS

This review contributes to Southend Together's Ambition of continuing to improve the outcomes for all children and young people.

THE WAY FORWARD

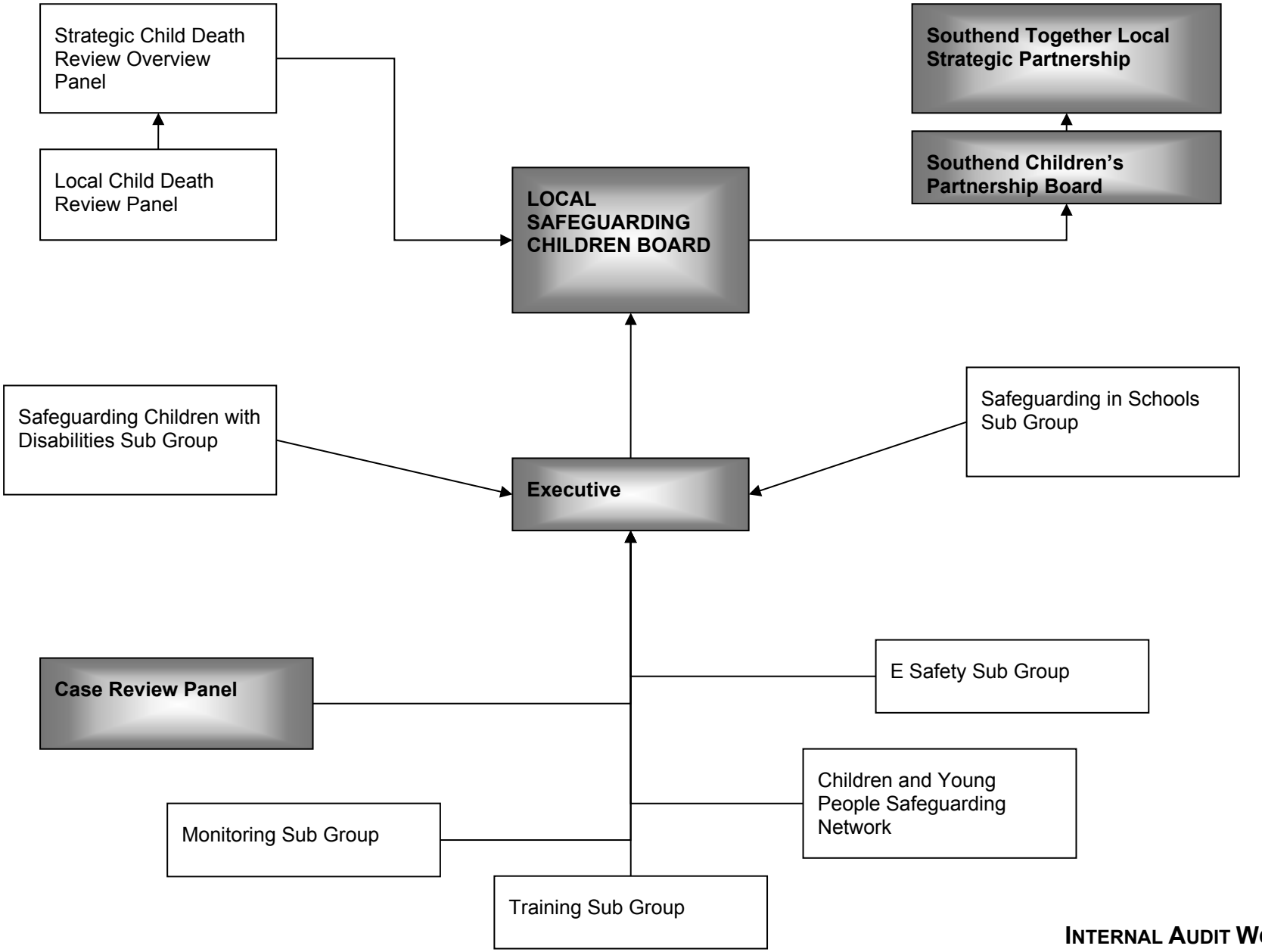
A detailed action plan for implementing the improvements in the processes described above is attached at Appendix B. Detailed arrangements and dates for the implementation of recommendations are in the process of being agreed.

As agreed dates for implementation of recommendations contained in Appendix B are reached, SBC's Internal Audit Team will confirm that evidence is available to demonstrate that they have been implemented.

Updates will be provided to the Head of Children's Specialist Services for onward reporting to the LSCB.

This report can be provided in alternative formats such as Braille, audio-tape or in large print. Translations of this document in alternative languages are also available.

APPENDIX A: LOCAL SAFEGUARDING CHILDREN'S BOARD REPORTING STRUCTURE



INTERNAL AUDIT WORKING GROUP

APPENDIX B: LSCB SERIOUS CASE REVIEWS: ACTION PLAN

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
R1	Define the LSCB process for monitoring the implementation of recommendations emanating from serious case reviews. This should define: • what information the LSCB requires from partners to satisfy itself that action plans are being addressed and that this should be supported by documentary evidence when any recommendation is to be signed off as implemented; • the function of the Case Review Panel in reviewing and challenging the quality of evidence supplied by partners; • the role of the Case Review Panel in changing the Red / Amber / Green status of recommendations as they become satisfied with the progress made in implementing recommendations;	Ineffective challenge that partners safeguarding arrangements are robust enough to protect vulnerable children?	LSCB Business Manager	H	Terms of reference for the LSCB Case Review Panel to be revised to include the process for monitoring the implementation of recommendations emanating from serious case reviews and other reviews undertaken by the LSCB as detailed	1st April 2011

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
	• the criteria for reporting progress in implementing recommendations up to the LSCB Executive Group and the main LSCB; and • the LSCB's expectation that, after the Case Review Panel has signed off recommendations, partners will require their internal audit teams to independently confirm the implementation of recommendations and report on this to the LSCB.					
R2	Extend the Case Review Panel's terms of reference to include: • the robust challenge of evidence supplied by partners in support of recommendations implemented; and • the responsibility for changing the red / amber / green status of recommendations when they are satisfied with the evidence.	The procedure for signing off recommendations is not robust and overall safeguarding practice regarding vulnerable children is not improved.	LSCB Business Manager	H	Terms of reference for the LSCB Case Review Panel are amended	1st April 2011

APPENDIX B: LSCB SERIOUS CASE REVIEWS: ACTION PLAN

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
R3	Improve the minutes of the Case Review Panel so that they provide better evidence of discussions had and decisions made with regard to the implementation of recommendations.	The status over the implementation of recommendations becomes unclear, actions are not addressed reducing the overall assurance that children's safety has improved.	LSCB Business Manager	H	LSCB Case Review Panel minutes format is revised. Case Review Panel minutes comprehensively evidence discussions and decisions regarding the implementation of recommendations	From January 2011
R4	Define an approach to assessing the risks attached to issues identified from serious case reviews and prioritise the importance of recommendations accordingly.	Attention is not focused on addressing the most serious weaknesses in partner safeguarding arrangements.	LSCB Business Manager	H	LSCB Case Review Panel defines and implements a risk assessment process which prioritises the importance of recommendations from serious case reviews	1st April 2011
R5	Integrate the monitoring of high level risks / high priority actions into the LSCB Executive Group's assurance arrangements.	High level risks / high priority actions are not consistently challenged reducing the overall assurance that safeguarding practice has improved.	LSCB Business Manager	M	Progress of serious case review recommendations identified as high risk/priority are reported on a quarterly basis to the LSCB Executive by the LSCB Case Review Panel	From April 2011

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
R6	Reconvene the Case Review Panel and require that partners submit the remaining evidence to support the implementation of actions required from the Baby R case.	Reduced overall assurance that the lessons learnt from the Baby R case have been addressed.	LSCB Business Manager	H	Meeting of the LSCB Case Review Panel and other partner agency representatives contributing individual management reviews to the Baby R case to submit remaining evidence to support the implementation of recommendations from the Baby R case.	31st May 2011
R7	Require that the Foundation Trust undertake an independent review of their arrangements for implementing recommendations from serious case reviews and formally report the results to the LSCB. The review should cover: • where process improvements need to be made these are clearly communicated and understood by staff; • there is clear officer accountability for addressing the actions; • there are procedures in place to monitor the implementation of recommendations made; and	Reduces the LSCB's overall assurance that the lessons learnt from serious case reviews are improving the safety of children.	LSCB Chair and LSCB Business Manager	H	LSCB chair writes to the chief executive of the Foundation Trust requiring an independent review of the arrangements for implementing recommendations from serious case reviews. The Foundation Trust to report the findings to the LSCB	1st April 2011

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
	• whether there is sufficient evidence to confirm that the recommendations from the Baby R case have been addressed.					
R8	Require that partners' internal audit teams formally sign off the implementation of recommendations from the Baby R serious case review (after the Case Review Panel have completed their sign off).	The challenge and review of evidence is not consistently applied reducing the LSCB's overall assurance that the lessons learnt from the Baby R case have improved overall the safety of children.	LSCB Chair and LSCB Business Manager	H	LSCB chair writes to the chief executive of the partner agencies involved with the Baby R case requesting that internal audit teams review and sign off the evidence and that the "sign off" is confirmed to the LSCB. Initial letter to go to agencies prior to the end of the 2010/11 year in order that this can be incorporated into Internal Audit Plans for 2011/12.	June 2011 31st January 2011
R9	Require all partner internal audit teams to include the follow up of serious case review recommendations in their routine follow up processes of audit recommendations previously agreed. Request reports when evidence is insufficient to sign off recommendations.	Reduced assurance that lessons learnt from serious case reviews are being addressed and practice has improved.	LSCB Chair and LSCB Business Manager	M	Terms of reference for Case Review Panel to be revised to include requirement for partner agency internal audit teams to include in their routine follow up processes of audit recommendations previously agreed.	1st April 2011

	RECOMMENDATION	RISK IF NOT ACTIONED	LEAD OFFICER	H M L	AGREED MANAGEMENT ACTION	ACTION DATE
	(This process should be added to the LSCB's assurance framework in the area of serious case reviews).				LSCB chair writes to the chief executives of all partner agencies requesting that the implementation of actions from SCR are absorbed into partner internal audit teams' follow ups of previously agreed recommendations. Baby K case will be highlighted as the first case where this process can be introduced.	31st January 2011