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Eastern Region Sector Led Improvement Programme

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Ref: Regional Peer Review
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Regional Peer Review

Dear Simon

I am writing to set out for Southend the formal feedback from the peer review that took place between September 16th to September 19th 2015. This letter will cover in more detail the presentational feedback, but the key and salient points were shared with Southend at the presentations on the 19th September.

Firstly can I thank you formally for the organisation, hospitality and the spirit in which Southend entered into the review. The peer team would like to thank all those that participated in this process. We aimed to use our experience to reflect on the evidence you presented on safeguarding vulnerable children and young people. This was not an inspection, although we utilised the guidance for Ofsted's unannounced inspections of local authority arrangements for the protection of children to provide a consistent approach.

The peer team provided verbal feedback to yourself on the final day on-site and we agreed to send you a letter confirming our findings. This letter sets out a summary of our findings and comments are made with the intention of supporting you in this sector led process. As you know the Peer Safeguarding Health Check (PSHC) focussed on the front door, your early help offer, the first contact team and working with partners including the LSCB intervention. The key lines of enquiry were:

- The Journey of the child through the service.
- Quality of Practice, management and supervision
- Leadership and governance including partnership working and the work of Southend LSCB.

The peer team utilised the Ofsted document "*Inspections of arrangements for the protection of children"* (Ofsted 110133 January 12) to arrive at their thoughts against each evaluation schedule to provide strengths and areas for development.

We will now explain against each of the evaluation schedule elements, the strengths and areas we have developed, together with the evidence we used to reach our conclusions.

The Journey of the Child through the Service

One of the strongest impressions throughout the course of the review was the commitment of staff at all levels to Southend and to delivering services for children and young people and we found many strengths. There is a strong emphasis on ensuring children are safeguarded both within the department and from partners. There are well developed early help services and the First Contact Team is a well resourced and effective team. The workflow is effectively monitored and processes are in place to manage drift. We found that referrals were responded to promptly, children were seen without delay and there was evidence of direct work with children and families. One social worker talked about using the Three Houses Model and others described their work with families to identify issues and promote change.

Team Managers in the first Contact Team ensured threshold decisions were well recorded and consistently applied and section 47 enquiries seen were appropriate. We observed the multi agency early help panel where cases are presented and a decision made regarding the level of support needed.

We understand that resources have been put into improving Southend's prevention, identification and response to Child Sexual Exploitation (CSE) and missing children and there is now a lead officer for CSE. One of the cases we audited was of a young woman where there was a strong suspicion she was subject to CSE, the social worker had managed the risk well and promoted change for the young woman which had significantly reduced the risk. As Southend have recently had a Peer review of CSE and due to time constraints we did not cover this area in more depth.

The areas for development we identified were that in the First Contact Team there was a risk of over dependence on two individuals who played a key role in decision making. Whilst they both performed well, we were concerned that the team might not run quite as effectively or with the same consistency if those individuals were not present. The council should reassure itself on this issue. In our limited audit of cases we identified that some cases were opened for assessment and closed again very quickly or did not meet the threshold. Within these events there was an overreliance on the tenacity of others i.e. when referrals were made to community groups/project to ensure plans were followed through. On the other hand there is not a high re-referral rate in Southend so a greater number of closed cases and those not meeting the threshold for social care would need to be tracked. We also briefly looked at transitions between teams from the child's perspective and had some concern that it might not be in a young person's best interests to change to a new social worker at 16.

We also thought that your family group conferencing service could be used to facilitate positive outcomes at an earlier stage in some of the work we looked at.

We audited several cases where domestic abuse (DA) was prevalent and this led to the Peer team exploring Southend's response to DA in more depth. We had some concerns that the journey of a child subject to DA is not straightforward and could cause delay. It is a positive

that the police processing DA referrals are based in your office and are part of the team, however as yet the information overall is not collated effectively for an overarching analysis to be made and involves using different systems to get a full picture of the situation and assess the risk and level of intervention required. We were also concerned that those cases assessed as medium risk did not have a defined route into early help services. The Essex wide MARAC is confusing and decisions are being made outside of Southend's control with some delay in cases being heard. We were told that the council is aware of this and plans are in place to expand the agency membership of the JDATT which will support further improvements in risk assessment and decision making.
For those high level cases where a referral was made to the First Contact Team for assessment we would recommend that a more useable tool for the effective assessment of risk in DA is considered.

We observed that some cases were closed with a lack of tenacity in pursuing all parties, including fathers, for their views and that there was an overreliance on programmes to address DA in the absence of building resilience in children. As an example of this one of the cases we audited was closed where we were not confident that the assessment had addressed the risks for the children. We note that when we presented our findings and concerns regarding your response to families where DA is prevalent, you advised that Southend intend to develop a more specific DA service within early help to address some of the issues raised, in particular for those families assessed as medium risk. We also noted that there is an Essex wide lack of programmes for perpetrators who are not in the criminal justice system and this may be another area for you and partners to research. This is being addressed at a strategic level across the county.

The evidence we used in particular with regard to the department's response to families where there were identified concerns regarding DA was gathered from individual case audits and discussions with practitioners, meeting with the police DA team, Head of Social Work, Service Managers, Team Managers and Senior Practitioners and from observing the Child and Family Panel.

Quality of Practice management and supervision strengths

We saw good evidence of direct work with children and families and recording was up to date and timescales met, good practice was seen in many of the audits but variable overall. The social workers we spoke to were very positive about working in Southend, felt their caseloads were reasonable and that they were very well supported by Managers. CPD is good and ASYEs were very positive about their experience and support. The Group Manager Fieldwork is seen as very supportive and has a good knowledge of cases and regularly audits and reviews work.

We saw evidence of outstanding practice where social workers had carried out good assessments engaging with all relevant family members, ensuring the voice of all the children in a family were heard and carrying out direct work to achieve positive outcomes. Where significant risks were identified child protection and legal proceedings were robustly applied. We saw evidence of clear and quick decision making by Team Managers to secure the safety

of a child. We audited one case held by an ASYE who had done an excellent assessment and work relating to an unborn child where she had been well supported by managers in making difficult decisions regarding the child's future.

Team Managers had good knowledge of cases in their teams and good relationships with early help managers. Cases transfer between social care and early help in a timely way and thresholds are well understood. Early help services are well developed and effective. Strengthening families model has been implemented for case conferences and was used effectively in the ICPC we observed to engage the family. We were told that CIN cases were routinely reviewed and managed and we viewed the appointment of a CIN reviewing officer as positive. Both the CIN review and the CP conference we observed were well chaired. The CIN review was for a child in private fostering and your service for private fostering seemed well developed.

The areas for further consideration mainly related to 4 of the 12 audits raising concerns regarding the recording of the quality of practice. These concerns had been identified by yourselves in auditing the cases and some of them had been robustly addressed. The concerns identified were around the quality of assessments, the lack of clear or SMART plans and poor assessments leading to cases being closed without identifying all risks or engaging with all family members. Some of the areas for further consideration related to historical rather than current practice. We found assessments and plans difficult to access on Care First which we understand is in the process of being replaced. We noted there was a lack of supervision notes or management decisions on some files and rationale for decision making on a child's file needs to be improved. Supervision and lines of accountability were unclear to us and we would have wanted to explore the role of the Team Manager and Senior Practitioners in supervision and decision making in the First Contact Team in more depth to ensure the Team Manager ratified decisions made and was accountable for all the work in the team.

Early help services appear well developed and embedded but the different teams could lead to some confusion or overlap regarding which team would be most appropriate to provide an identified service. We would recommend that consideration is given to bringing all early help teams into a more unified service.

In our meeting with the IROs we were not reassured that the IRO escalation process was being used appropriately and there was an overreliance on informal escalation to Team Managers which might not be followed through. We were shown examples of the escalation process being used leading to resolution of the concerns.

The strengthening families model in conferences is effectively in place but would have been improved by changing the report format for the social worker and partner agencies to fit with the model. We would recommend that a 'danger statement' or 'what are we worried about' statement and safety goals were considered at the conference.

Leadership and governance

We found many strengths in leadership and governance. The Peer review Team met with the Lead Member for Children, the DCS, the Head of Childrens Services, a group of members from the LSCB and had a telephone discussion with the Chief Executive.

The council is committed to Childrens Services, safeguarding children is seen as a priority and both early help and social care provision are well resourced. There is a strong vision of children's services across the partnerships and previously identified strengths in partnership working have been maintained and built on. Areas of concern have been identified for example health provision for CWD and CAMHS and are being addressed.

Performance management is good and senior managers and partners use the management information to track areas for improvement. The auditing process including multi agency audits is embedded and themes from audits are explored.

The department is well staffed with a low number of agency social workers. Staff report that over the last 2 years support and practice has improved. Staff seem happy in their work and work environment and well supported by all tiers of management. They are proud of the work they do and of the department and should be encouraged to share the pride in their work.

Areas for consideration under leadership and governance relate firstly to the audit framework which does not sufficiently involve Team Managers and needs to engage further with frontline staff to enable them to demonstrate the impact of audit on practice. We would recommend that Team Managers carry out regular monthly audits and that these could be quality assured by Senior Managers.

Whilst thresholds appear to be well understood across the partnerships, the document known as the Early Help Toolkit is in our view not very clear regarding the different levels of need and consideration could be given to updating this or a new punchier booklet being developed.

We also carried out an Annex A information check and this highlighted some gaps in documentation and some documents were out of date. We recommended that increased resource might be needed to address this.

Summary

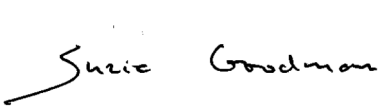
The review team only had limited time and if we had been on site for a longer period we would have pursued some of the themes we identified further. Overall we were impressed with much of the work we saw, with the enthusiasm of staff and support from managers at all levels. Partnership working was well embedded and there was evidence of good partnership working.

Our key messages and recommendations are that the Department need to

- Develop confidence that practice is consistently of a good standard and address robustly the key practice concerns identified in audits.
- Consideration should be given to making the audit process more inclusive for Team Managers and Social workers.
- Staff appear to be well managed but this is not sufficiently evidenced on case files
- Management decision making on cases needs to be more visible and level of decision making and accountability clarified
- Develop a deeper understanding of the practice model of Strengthening Families and the depth to which you apply the model and the implications for Partner Agencies
- Critically appraise Southend's approach to domestic abuse and to conditions which need to apply before a case is closed

The peer review team would again like to thank all those who participated. Should further information be required on any of the points raised in this letter we would be happy to provide more detail.

Yours Sincerely



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