Suffolk Safeguarding Children Board

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Progress Report for the September 2014 LSCB meeting on the Family 'A' Action Plan.

1. Introduction

1.1 Between May and December 2013 Suffolk LSCB led a Serious Case Review into the deaths of Fiona Anderson and her 3 children in Lowestoft. The final report was presented to the Board who accepted in full the 'lessons learnt' and an LSCB Response was prepared and published in January 2014

1.2 The Response outlined the actions that had already been taken, their impact and other actions required to address the learning. These were developed into an Action Plan, the progress of which has been monitored by the LSCB Case Review Panel.

1.3 This report aims to provide an update to the LSCB on whether the progress and/or impact reported in the LSCB Response on actions already taken has been maintained and also on the progress and impact of additional actions identified. It should be noted that the Executive Group received a draft report on 2nd September 2014 that contained more detailed information about some areas of performance and following discussion asked that the amount of detail be reduced to enable this report to be 'more manageable' at the Board meeting.

Lessons Learned

2. Working with avoidant families – Learning 14.1

2.1 *Working with hard to reach and avoidant families is very challenging for professionals and has impact upon the parents in the anxiety it creates for them and for the loss of the benefit of receiving supportive services. Innovative multi-agency interventions and new initiatives are likely to be required to engage parents in a more constructive working alliance. There is considerable research and literature on this subject which can give direction to practitioners and managers on how to attempt different strategies and achieve effective outcomes*.

2.2 Prior to January no action had been taken with regards this learning but the following were agreed;

2.3 **ACTION.** ***The LSCB Planning, Policy and Engagement Group will review, revise and re- publish current practice guidance on working with hard to reach and avoidant families. This will involve a partnership approach including input from Norfolk and Suffolk Foundation NHS Trust to provide direction on how practitioners can utilise different strategies and achieve effective outcomes where there is no remit for statutory involvement of mental health services. The LSCB will co-ordinate an awareness raising campaign to re-launch the revised policy. (By Sept 2014)***

2.3.1 The LSCB Manager reports that LSCB guidance has been revised and includes a reference section to provide research and good practice guidance for practitioners. Input from the Suffolk Wellbeing Service has resulted in the inclusion of information to provide direction for practitioners to achieve effective outcomes where there is no remit for statutory involvement of mental health services.

The revised guidance has been approved by the LSCB Policy Practice and Engagement Group (PPE) and will be widely disseminated and available on the LSBC website by the end of September 2014. A three day conference jointly sponsored and co-ordinated by the LSCB was held at University College Suffolk in early September. The keynote session on the first day was entitled 'Working with resistant, reluctant and hostile service users' and led by Jim Wild from The Centre for Active and Ethical Learning in Child Protection and Adult Change. The conference was also used by the LSCB Support Team to raise the profile and re-launch the new guidance. Other presentations at the Conference included the ACCORD Protocol and 'Using a Psychological Framework to Inform Multi Agency Working'.

2.3.2 As part of the LSCB Response in January it was recognised that there needed to be a mechanism for professional consultation from mental health services when there are professional concerns as to the mental and emotional wellbeing of a parent, but no clear diagnosis (referred to at paragraph 7.2 of this report). The Suffolk Wellbeing Service has confirmed that their service can be utilised in two ways;

- By providing clear information and access to services via their website to allow practitioners to support parents to receive the appropriate services, support and resources to improve emotional wellbeing; and
- To provide support, advice and guidance to professionals working with the family via phone consultation with the Duty Manager in the Wellbeing Service. This will include, where appropriate, and where the professional discussion highlights a complex concern, a referral to the Access and Assessment Service where a referral can be triaged and directed to the right place.

2.3.3 As this guidance has only recently been disseminated there is no evidence of impact. However, as the action was to review and publish guidance the Board are asked to agree this action as 'completed'.

2.4 **ACTION.** ***The LSCB will initiate a review of the current multi agency training programme including that of Child Protection Leads in schools to ensure it adequately covers good practice with hard to reach and avoidant families. (By July 2014)***

2.4.1 Suffolk County Council CYPS/ACS Workforce Development have given assurance to the LSCB Manager that lessons from the Serious Case Review have been incorporated into training and that specialist training has been commissioned by them for the 2nd September 2014. They also confirm that an explanation of Public Law Outline has also been incorporated into training. Dissemination of a link to Department for Education (DfE) Legal Processes online training resource has gone out to all staff in CYPS. From the Spring of 2014 training for Newly Qualified Social Workers has included information about this Serious Case Review and the lessons learned.

The new Designated Lead one day and Designated Lead refreshers ½ day programme (for child protection leads in schools) features the Family 'A' case study looking at the lessons learnt and is due to be rolled out from September 2014. Previous to this in January 2014, following the publication of this SCR, the 285 Safeguarding Leads across the County received a legal update including reference and signposting to the LSCB overview report. Since then a further 275 staff (over 11 courses) received the SDP one day training which included the lessons learnt from the overview report.

The content of the Multi Agency training is now as follows:

- Additional information on the assessment framework triangle and safeguarding thresholds
- Information on the Signs of Safety and Wellbeing approach
- Information on post referral procedures and the work of the MASH
- Information on the range of tools and strategies already in place to support families such as the Accord Protocol, Family Group Conferences, support from external agencies
- Case study work using the DfE Childhood Neglect materials
- Updated video materials on Child Protection Conferences
- Learning from Suffolk Serious Case Review

2.4.2 The expected impact of the changes and additions to training should be that safeguarding leads in schools and staff across the multi-agency partnership will have a better understanding of the difficulties of working with hard to reach families, the LSCB documents available on the website that may assist, a clearer understanding of the Public Law Outline and the lessons learned from the Serious Case Review.

2.4.3 It is suggested the Board agree this action as 'complete'.

2.5 **ACTION.** ***The LSCB will identify best practice and research on the impact of working with families where avoidance is a pattern of behaviour and enhance the above practice guidance to improve the skill of the workforce accordingly.*** **(By July 2014)**

2.5.1 The LSCB Manager confirms that the revised LSCB protocol on working with hostile and evasive families includes a 'References and Resources' section. This includes listings of local resources to assist practitioners to support families and identify areas of support and links to research, including that published by c4eo, Barnardo's and the DfE. This research provides guidance and information on assessing risks, effective practice to protect children living in 'highly resistant families' and government publications on the analysis of SCRs.

Specialist training has been commissioned by Workforce Development to take place in early September.

2.5.2 As this protocol has yet to be disseminated there is no evidence of the impact of the revisions and additions. However, it is anticipated that practitioners will feel better informed as to the resources available to support them to work with families and they will have a clearer understanding of the research behind good practice recommendations.

2.5.3 Although technically this action is complete, as the information is included within the policy, no evidence has been collected to demonstrate an increase in usage of the policy and the impact that has had on practice. It is therefore recommended that the LSCB note the progress of this action and require a further progress report to address those issues in March 2015.

3. The Experience of the Child – Learning 14.2

3.1 *An effective way to identify whether emotional abuse or neglect exists within a family is to focus on the experiences of the children and identify what the impact of any emotional neglect might be. Practitioners need effective supervision and support to enable them to retain a child focus and assess their behaviours and development within families where the parents have high levels of need.*

3.2 The January LSCB Response recognised that strategically over recent years Suffolk County Council Children and Young Peoples Services (SCC CYPS) had redesigned services to increase early intervention and improve capacity for reflective practice taking account of Professor Munro's Review of Child Protection finally published in May 2011. Also, that in order to strengthen and embed the changes in front line practice, CYPS had invested in a 3 year programme of practice development introducing the Signs of Safety and Wellbeing model. The aim of this is to ensure that practice improves in clarity and precision with regard to the risk to children, and the strength of families to protect them, including particular emphasis on the experience of the child in the household. The Response also recognised that the LSCB was leading the development of a new Assessment Framework, within which the Suffolk Signs of Safety and Wellbeing approach will be delivered, and that in July 2013 SCC CYPS had strengthened the monitoring arrangements for checking the frequency of supervision for all frontline staff with a report on this received monthly by a Service Director.

3.3 The January Response reported the impact of this redesign work as having:

- stabilised the number of Looked After Children;
- reduced the numbers of Children in Need;
- increased the numbers of families supported early;
- managed the workforce across the county to ensure that in most areas the capacity meets demand; and
- created more stability in the system to allow for reflective child centred practice

It also reported that since the new supervision monitoring arrangements were introduced 98% of staff in Lowestoft has consistently received monthly supervision and that in respect of Suffolk Signs of Safety and Wellbeing, a full training programme for SCC staff would start in February 2014 with plans to train 1100 staff by October 2014.

3.4 The following further actions were agreed by the LSCB:

3.5 **ACTION.** ***Reports presented to future LSCB meetings on the progress of the implementation of the Suffolk Signs of Safety and Wellbeing programme will include information and evidence on how this has improved practice in relation to practitioners focussing on the child's view and experience. (From July 2014 to July 2015).***

3.5.1 A Programme Impact Report compiled by Lyn Baran, Project Lead for Suffolk Signs of Safety and Wellbeing, was submitted to the LSCB on the 14th July 2014. This was the first impact and performance report relating to the implementation of the new practice framework for children's services within Suffolk County Council: Suffolk Signs of Safety and Wellbeing. Project management arrangements were put in place towards the end of 2013, and an implementation plan developed for the period 2014 to 2016. This was designed to support the organisation and its practitioners to embed the new way of working and to engage partners in understanding the changes this will bring for them and also to garner their support for this new approach. The implementation plan has three key elements – leadership, learning and systems review. The implementation plan is also designed to promote cultural change thus ensuring purposeful engagement with families, which secures better outcomes for children. A key principle is that families should be empowered to take responsibility for their own lives, harnessing natural networks of support. The practice framework uses the internationally recognised Signs of Safety practice model developed in the 1990's by Dr Andrew Turnell in Australia.

3.5.2 Achievements to date include;

- 46 briefing meetings have been held for staff within the CYPS Directorate and 18 sessions held for partner agencies, arranged through locality manager contacts or in response to communications. Agencies contacted in this way include schools, the police and voluntary sector organisations.
- 653 SCC staff have completed the 2 day Introduction to Signs of Safety training (21 courses have been completed with an average attendance of 31 people on each). This represents approximately 50% of the target internal audience, with the remainder scheduled to complete training by the end of the calendar year.
- 84% of attendees rate the training as good or excellent
- 2 days bespoke training for CP Chairs, their managers and administrators. Total of 40 attendees.
- 65 team leaders and supervisors have completed an additional 5 day 'Intensive Signs of Safety Training Programme' to equip them to become Practice Leads. By April 2015 two further courses will have taken place resulting in a total of around 180 trained Practice Leads.

3.5.3 The project includes a suite of success measures which will form the basis of impact and performance reports over the lifetime of the programme. Completing a Signs of Safety assessment well is likely to significantly sharpen analysis and produce more effective plans that have traction with families and networks of support. Early feedback is consistent with this. Although some

meetings are taking more time they are generating better quality information and analysis with fewer, more pertinent, actions agreed that are better focused on child safety and wellbeing. The feedback also shows that professionals who adopt the new practice framework are able to have an immediate impact, which is noted by partners and families.

Example 1

"I just wanted to say thank you for coming and chairing the meeting today. J's mum was very positive afterwards and commented on how your genuine and respectful treatment of her as a person had enabled her to speak much more openly and that she had felt listened to and not judged as a person or parent. We all felt that the meeting could not have been more different from our previous experience….

> *I certainly came away feeling that this TAC (Team Around the Child meeting) had been truly therapeutic in a way that I don't think I have ever experienced before. I believe your sensitive, authentic, and compassionate approach to applying a solution focused model was critical in making this happen…. and if this can be encouraged and practiced more widely, I have much more hope for the future of TAC as vehicle for change that happens 'with' the children and families we work with rather than 'to' them. "*
>
> *Principal Clinical Psychologist. South Suffolk TAC May 2014*

Example 2:

"I made a home visit to a school refuser who often refused to get out of bed. I started off by explaining that I had just been on training and would like to practise what I had learnt with her. She agreed. I worked through the three houses with her and the covers were lowered from over her head until she was sitting up and interacting. I asked her scaling questions which she also found helpful. When I had finished – she dressed and came downstairs to continue the discussion with her Mother who had also completed the three houses and the scaling. As I left, Mum told me this had been the most helpful meeting of any she had attended with professionals."

CAF/ TAC Coordinator Ipswich June 2014.

3.5.4 University Campus Suffolk have been commissioned to undertake a longitudinal impact assessment of the Suffolk Signs of Safety and Wellbeing programme and this will deliver a range of both qualitative and quantitative information. This work commenced in July 2014. The detail in the success measures report will increase over time as new measures come on stream and the framework becomes more embedded in practice.

3.5.5 As this work is an ongoing project it is suggested the LSCB require a further update in March 2015 to include detail of the numbers trained, information from the UCS evaluation and more evidence of how this approach has improved practice in relation to practitioners focussing on the child's view and experience.

3.6 **ACTION.** ***The LSCB will continue to lead on the implementation of the Statutory Assessment Framework and during the planned formal review in July 2014 will require evidence of how well the 'child's experience' element of the framework is being implemented. (Report in July 2014)***

3.6.1 The drafting of the Suffolk Statutory Assessment Protocol coincided with the county-wide introduction of the Signs of Safety and Wellbeing (SOSWB) practice model. This led to a constructive delay in the launch of the process to ensure the framework was designed for maximum 'match' with the SOSWB approach, and therefore most ease of use by practitioners. In addition, for similar reasons, the Task and Finish Group also took on responsibility for revising and re-launching the Common Assessment Framework (CAF) form. For these reasons, and challenges with aligning Information Technology requirements, full completion of this action has been delayed.

3.6.2 On 14th July 2014 the Board received a report from David Jacobs, Interim Head of Specialist Services, CYPS announcing that both the Statutory Assessment Framework and revised CAF Process had been launched in early May. In terms of the former it outlined that evaluation will be two fold. 'It will include seeking detailed feedback from practitioners and first line managers (on line surveys, interviews and focus groups) so their experiences can be key to further development of the framework in order to further enhance practice – in accordance with the principles of SOSWB. It will also need to include feedback from partners as to their experience of, and involvement in, the new assessment process and timescales.' The early indications are that the changes have been well received by practitioners.

3.6.3 Suffolk CYPS work to Quality Practice Standards which include the following values. These are underpinned by the 3 core principles behind the Suffolk "Signs of Safety and Wellbeing" Framework; building constructive working relationships, having a stance of enquiry, being prepared to admit you may be wrong, using practice based evidence, and listening to workers and families as to what works.

Values

- The needs, rights and views of the child are at the centre of all practice and provision
- Individuality, difference, and diversity are valued and celebrated

- Equality of opportunity and anti-discriminatory practice are actively promoted
- Children's health and well-being are actively promoted
- Children's personal and physical safety is safe guarded whilst allowing for risk and challenge as appropriate to the capabilities of the child
- Self-esteem and resilience are recognised as essential to every child's development
- Confidentiality and agreements about confidential information are respected as appropriate to the capabilities of the child
- Professional knowledge, skills and values are shared appropriately in order to enrich the experience of children more widely
- Best practice requires a continuous search for improvement and self-awareness of how workers are perceived by others

The multi-agency task and finish group took these into account, together with feedback received from children and their families on their responses to social work intervention and together they helped shape the design of the Suffolk Statutory Assessment Framework,

3.6.4 The LSCB (at their meeting in July) acknowledged that due to the delay in implementation there had not been sufficient time to adequately evaluate the new process and identify the impact it was having. The Board agreed that the Task and Finish Group should continue and should be responsible for conducting the evaluation at the end of October and reporting the results to the December 2014 Board meeting.

3.6.5 It is recommended the LSCB note the progress of this action and in addition to the individual report to the Board in December 2014 require a further progress report, as part of the Family 'A' Action Plan Review in March 2015.

3.7 **ACTION.** ***On a quarterly basis over the next twelve months, SCC CYPS will provide a report to the LSCB Learning and Improvement Group evidencing the continued consistency of supervision across the County. (Ongoing to March 2015)***

3.7.1 In the LSCB Response it was reported that in July 2013 SCC CYPS strengthened the monitoring arrangements for checking the frequency of supervision for all frontline staff and that a report on this is received monthly by a Service Director, at the time John Gregg. Although the focus of the SCR was on working arrangements in Lowestoft the LSCB were keen to see

evidence that effective supervision was taking place and was monitored in a consistent way across the County.

3.7.2 Although the report presented to the LSCB in July 2014 touched on supervisory arrangements in Lowestoft no report has been received by the LSCB Learning and Improvement Group (L&IG) since January addressing the consistency of supervision across the County. This omission was raised with the Head of Safeguarding after the Board meeting who undertook to arrange for information to be provided for this report.

3.7.3 As a result David Jacobs, Interim Head of Specialist Services, CYPS provided a report in August which stated that data with regards supervision sessions should be recorded within a team schedule spreadsheet, for ease of reference by managers and to enable the transfer of findings to the monthly Safeguarding Manager (SM) report. He indicated there has been variable success in this system, dependent upon team circumstances, including capacity of business support, which has meant that some localities have been unable to report (and evidence good compliance rates, with exceptions/gaps, largely relating to staff absence or temporary changes in management etc), and others not reporting consistently.

3.7.4 Between January and March 2014 the Response indicated that 98% of supervision meetings were taking place in Lowestoft. The Interim Head of Safeguarding now reports that unfortunately this position has not been maintained. Immediate action has been taken to remedy this and is reported under paragraph 6.5. It is suggested that this has been as a direct result of 6 locum and 3 permanent staff leaving and a Practice Manager being absent through sickness with the combined impact of this being that supervising responsibilities of Senior Practitioner have suffered as they have, through necessity, taken on caseloads.

3.7.5 A more in depth analysis of supervision in Lowestoft by CYPS showed that a very recent SM audit has identified good compliance with frequency requirements in the **12+ CIN team**, that staff sessions are scheduled for the year and Carefirst (CYPS IT case monitoring system) evidences recording of supervisory oversight on children's files.

However, significant deficits in supervision arrangements have arisen in the **0-11 CIN team** over a period due to the extended absence of one PM and the SPs carrying caseloads too high to facilitate their supervisory duties. In an attempt to improve the situation a PM has resumed supervisory roles for all her team and covered those of her colleague PM too when he was absent. In addition a new, non-caseholding SP (p/t) has taken on responsibility for AYSE peer supervision, with support from Work Force Development.

The Looked After Children (LAC) Team SM audit has found evidence of good supervision provided but there are issues now being addressed regarding the typing up of records and maintaining frequency in context of intermittent sickness absence and the team experiencing high level of change in staff turnover.

3.7.6 In contributing to this report the Interim Head of Safeguarding acknowledges that elsewhere across the County the situation with regards supervision audits is not yet fully embedded

3.7.7 In order to address these identified issues and improve supervisory arrangements David Jacobs reports the following actions;

- Jacqui Gould, Service Manager (SM) Lowestoft has undertaken an immediate audit of supervision and shared these results with her Practice Managers. This showed that standards and frequency of the required supervision is not being met and immediate supervision training has been provided by Practice Managers in Team Meetings.

- The Interim Head of Specialist Services is reviewing team manager and supervisory capacity in Lowestoft (including oversight of cases within PLO) with the SM, given concerns regarding the consistency of oversight being achieved. It should be noted though that oversight of PLO cases is being enhanced by the new county “permanence tracker” owned centrally by corporate parenting.

- The monthly SM Performance Report was reviewed and updated on 29th August 2014, with the assistance of Anne Goldsmith, Independent Consultant. These updates will address changed assessment reporting requirements and will include reporting on compliance with supervision policies, identifying strategies that can be maintained to facilitate reliable and consistent reporting.

- The current Supervision Policy and auditing process and template has been reviewed (including updating in respect of SOSWB practice) and being presented to Policy & Procedures.

3.7.8 The original action intended that reports be presented over a 12 month period so it is suggested the LSCB note the progress to date and challenges identified and confirm the continued need for report requiring a progress report to be presented to L&IG in December with a full update presented to the LSCB in March 2015.

4. Eliminating drift in the Child Protection Process - Learning 14.3 14.4, 14.9 and 14.13

4.1 *To allow Child Protection Plans to continue unaddressed throughout a number of Child Protection Conferences means that the children will continue to be subject to significant harm whilst still within the child protection process.*

The role of the Child Protection Conference Chair is a pivotal one in challenging the management of a case that is not achieving Child Protection Plans and by inference, it is maintaining children in at-risk scenarios

When cases are not progressing in terms of the protection of children, and the multi agency process has become entrenched, if there is no separate process utilised to objectively review why the case has become problematic, then the children would continue to be at risk of significant harm, and the multi-agency interventions become further entrenched.

To fail to record important discussions and agreements reached between Child Protection Conference Chairs and managers outside of the Child Protection process, will mean that any actions agreed to ensure that a case is properly progressed, cannot be effectively reviewed or monitored and could enable management drift to occur.

4.2 The LSCB accepted this learning and acknowledged the vital role that Child Protection Conference Chairs and agency partners play in ensuring that Child Protection Plans have clarity and pace to effectively protect children and that drift is swiftly addressed**.** The January report outlined that the following actions had already been taken:

- The SCC CYPS escalation process for case concerns arising from the Safeguarding Service was revised in April 2013.
- A full review of the Child Protection Conference system, including observations of the practice of Conference Chairs, had been undertaken by an independent consultant together with the SCC CYPS Interim Head of Safeguarding between July and November 2013
- From July 2013 all cases where a Child Protection Plan has been in place for 15 months are reviewed at the monthly meeting held between the operational service managers and safeguarding managers.

4.3 The report indicated that since these actions were taken there has been:

- A 17% reduction across Suffolk in outstanding concerns in the first quarter of the use of the revised escalation process. In Lowestoft there has been a 36% reduction;

- A 33.8% reduction in the length of time children are subject to Child Protection Plans over 18 months;
- 83% of Chairs of Child Protection Conferences have been independently assessed as good or outstanding.

4.4 The LSCB decided on a range of actions that would further improve this area of business so rather than attempt to provide a current position against the above this reports deals specifically with the actions.

4.5 **ACTION.** ***The LSCB Learning and Improvement Group will receive a progress report on improving the effectiveness of the Child Protection Conference system in January 2014 and this will go to the LSCB in March 2014 with recommendations for further actions. (March 2014)***

4.5.1 For many years practice at Child Protection Conferences (CPC) has been governed by LSCB Procedures but these do not address the qualitative aspects of the process. Although generally CPC Chairs would assume responsibility for this, based on the findings of this SCR and the Ofsted Inspection that occurred around the same time it was clear that there was an inconsistent approach to this. In June 2013 CYPS instigated work to address this through the introduction of a set of standards for conferences and in so doing shift the focus of chairs from managing what could be seen as bureaucratic processes to ensuring effective outcomes for the child.

4.5.2 In March 2014 the LSCB approved the 'Standards for Child Protection Conferences', a range of associated targets for 2013/14, changes to the LSCB procedures, priorities for multi agency practice change and the revised quality assurance process that would include LSCB Board Members observing and grading at least 1 CPC per year.

4.5.3 The Interim Head of Safeguarding reports that within CYPS a process for structured observations of CPC's has been agreed that will result in around 25 being evaluated by seniors managers per year. LSCB Members have also agreed to observe at least 1 per year so in total around 50 CPC's will be evaluated per year.

4.5.4 Since April 2014 a total of 9 CPC's have been observed with 7 (78%) judged as being good or outstanding. The 2 judged as inadequate were both so judged because of the failure by agencies to supply reports on time and not being in a position to address matters verbally. Based on the agreed standards such failures automatically result in an overall grade of inadequate. The general notes of both conferences suggest that had the reports been

available then they would have been graded as 'good'. These matters have been raised with the individual agencies concerned.

4.5.5 It is suggested that the LSCB agree this action as 'completed' but ask that the reporting of CPC judgements be incorporated into the further report required by the Board in March 2015 to address the outcome of the below actions.

4.6 **ACTION.** ***The LSCB require the SCC CYPS Head of Safeguarding to present a report at the July 2014 meeting to demonstrate the level of multi agency compliance with the policy on engagement, attendance and contribution to the Child Protection Conference system. (By July 2014)***

4.6.1 A report was presented to the LSCB in July by the CYPS Interim Head of Safeguarding that indicated that since April 2014 processes had been put in place to collect information about the attendance and contribution of non CYPS staff to evidence their contribution to the Child Protection Conferencing process. However, during this data collection it quickly became apparent that it was not a straight forward exercise and that much depended on the individual interpretation and judgement of the Conference Chair and therefore the resulting data would not provide consistent picture. For example, when considering attendance it is recognised practice that not all invitees are expected to attend every CPC and therefore the evidence of attendance could not be based purely on whether all invitees attended.

4.6.2 As a consequence the system was refined further and during August the results from the July data collection were considered. Although much better it was recognised that as the information still came from Conference Chairs and also involved their admin staff there were still inconsistencies in the reporting. As a result from the 1st September 2014 inputting and reporting on this data has been refined further and although still completed by CPC Chairs it will be signed off by one of the three County safeguarding Managers. This, together with changes to admin staff roles will result in only 4 people being responsible for the data. This will lead to much improved consistency and accuracy, which is essential as actions to address shortcomings will result from it.

4.6.3 Although data collection is still not perfect already the benefits of doing it can be seen. For example the July report identified a lack of consistency in respect of the police attending pre birth conferences. There was also an issue in the Ipswich area with police attendance at Initial Conferences. This has been drawn to attention of the police representative on the LSCB for him to address. It also showed that during July Health were in attendance at <u>all</u> Initial Conferences and schools/Children Centres attended <u>all</u> Review Conferences.

4.6.4 The Executive acknowledged that there is still some way to go to ensure this system is effective in driving up the standard of both CPC's and Review Conferences and was reassured that actions are in place to take this work forward. It is suggested the LSCB require an update report to be presented to the December L&IG and a further report presented to the Board in March 2015.

4.7 **ACTION.** ***On a quarterly basis over the next twelve months SCC CYPS will provide a report to the LSCB Learning and Improvement Group outlining:***

- ***Management oversight on plans that have been in existence over 18 months***
- ***The number of and resolution of concerns raised by Child Protection Conference Chairs.***
- ***The number of cases reviewed at monthly Safeguarding and Operational Manager meeting. (Ongoing till July 2015)***

4.7.1 Subsequent to this action being approved the LSCB Chair agreed that the first report would be presented in July, to the main Board. It was presented by the Interim Head of Safeguarding and although well received there were questions about the adequacy of the information to effectively gauge impact and also some concerns about potentially worrying trends. This report now seeks to update that information.

4.7.2 In terms of **management oversight of plans** that have been in existence over 18 months The Interim Head of Safeguarding reports that much progress has been made and significant reductions seen as a result.

Month	No. of children subject to CP Plan	No. subject to plan for 18 months or more	% of plans 18 months or more
April 2013	499	51	10%
April 2014	620	23	3.7%
May 2014	595	35	5.8%
June 2014	579	32	5.5%
July 2014	533	19	3.5%

The above evidences that the significant drop in numbers reported in January has been maintained throughout the first six months of this year. In addition it is important to note that although the numbers relate to individual children generally the number of families involved are half that number so for example although there are 19 children who have been subject to a CP Plan for 18 months or more in July this will probably only relate to 8 or 9 families.

More important than the figures is the fact that implementing the learning from the SCR has resulted in all of the above cases being reviewed in the monthly Independent Review Officer (IRO)/Practice Manager meeting and also the CYPS Service Manager/Safeguarding Manager monthly meeting. This has provided a duel level of management oversight and therefore the Board can be fully assured that all of the above cases were deemed appropriate to continue being the subject to child protection plans and that no drift in those plans had occurred.

4.7.3 Identifying and collecting **'concerns' arising from Child Protection Conferences (CPC's)** has previously been inconsistent so as a result a revised process has been introduced. The following tables identify the number of and resolution of concerns that Child Protection Chairs identified in respect of **CYPS staff.** These concerns are about practice issues and standards in CPC's and what CYPS measure is set out in the below charts under most common causes of concern. This is separate system to that of the chairs observations that are carried out where the conference is graded in relation to set standards that are in place for effectively keeping children safe.

Expressions of Concerns: Child Protection Conferences

Initial CP Conferences

Month	Number of meetings	Number of meetings with concerns	% of meetings where concerns have been raised	Total number of concerns possible	Total number of concerns raised	% of concerns raised within meetings held	Direction of travel	Concerns Resolved	Outstanding concerns
April	**30**	**5**	**16.6%**	**270**	**13**	**4.8%**		**11**	**2**
May	**27**	**6**	**22.2%**	**243**	**18**	**7.4%**	↓	**17**	**1**
June	**29**	**6**	**20.6%**	**261**	**17**	**6.5%**	↑	**15**	**2**
July	**34**	**2**	**5.9%**	**306**	**10**	**3.2%**	↑	**9**	**1**

Most Common Causes of Concern for Initial Conferences

	No chronology available	Report not shared with parents 24 hours before conference	Parent/child not adequately informed/ prepared for conference	Social work report not provided 24 hours before conference	Visits have not taken place according to timescales set out in the plan	Core assessment not adequately identifying risks/ protective factors	The protection plan has not progressed
April	5	3	3	2			
May	6	5		5	2		
June	2	8	3	1		3	
July	1	8		1			

Review of CP Conferences

Month	Number of meetings	Number of meetings with concerns	% of meetings where concerns have been raised	Total number of concerns possible	Total number of concerns raised	% of concerns raised within meetings held	Direction of travel	Concerns Resolved	Outstanding concerns
April	50	13	26%	450	76	16.8%		60	16
May	69	17	24.6%	621	52	8.3%	↑	41	29
June	73	10	13.6%	657	41	6.2%	↑	21	20
July	78	20	25.6	702	113	16.0%	↓	75	38

Most Common Causes of Concern for Review Conferences

	No chronology available	Report not shared with parents 24 hours before conference	Parent/ child not adequately informed/ prepared for conference	Social work report not provided 24 hours before conference	Visits have not taken place according to timescales set out in the plan	Core assessm ent not adequately identifying risks/ protective factors	The protection plan has not progressed	Sup assessments not progressed	Core group has not met as required
April	11	7		13	18	14	7	4	2
May	22	7		8	10	4			1
June	8	7	1	4	13		1	4	3
July	27	22		25	18		3	2	16

4.7.4 Analysis of these charts by CYPS has identified the need for further work to differentiate between the number of meetings and the number of children as for example one meeting can involve 3, 4 or more children. This means that care needs to be taken when interpreting some of the data.

4.7.5 However, it is clear from the data that the number of concerns arising from Initial Conferences is declining and in July showed a significant reduction with only 5.9% of meeting having a concern.

The availability of chronologies was a concern but as can be seen this chart shows performance improving. CYPS acknowledge that the main area that now needs to be addressed is the availability of the social worker report and in particular it being shared with parents 24 hours in advance of the meeting. Initial Conferences took place for 71 children in July and the figures show that in 8 (11%) of these the reports were not shared in advance. Not having these impacts significantly on the parent being adequately prepared. The data collection needs to be enhanced to show whether or not reports were available and shared immediately before the meeting.

4.7.6 Performance in respect of Review Meetings is of greater concern to CYPS. The dates for these are set either 3 or 6 months in advance and rarely changes so there is really no excuse for reports to not be prepared and circulated within agreed time scales. Overall concerns from reviews were reducing but July saw a significant increase which appears to be as a direct result of staffing issues in the West and North of the County.

4.7.7 The Interim Head of Safeguarding reports that in an audit of 171 children's plans 89.5% had been visited in the timescale stipulated in the child protection plan. It is of concern that 18 of those children whose cases were reviewed (10.5%) had not been visited as per the frequency set out in the Child Protection Plan. The charts show that looking back over the last 4 months this appears to be the norm with the average being 10.2%.If a concern has been raised that a visit within the specified timescale has been missed this is escalated as part of the escalation policy and is addressed in the monthly management meetings between practice managers and Conference chairs. If this cannot be resolved it is escalated to the monthly safeguarding / Service Manager meetings where action is taken. Any concern outstanding after 8 weeks is escalated to the head of Safeguarding and the Head of service for specialist services.

4.7.8 The provision of social work reports 24 hours before the meeting is being monitored. This shows 85.4% are received in the required timescale. However (14.6%) 25 reports from individual children were not being available. Again these issues are part of the escalation policy and these cases are addressed in the monthly management meetings

4.7.9 The importance of the availability and use of chronologies featured in this SCR. Of the 171 children who featured in reviews chronologies were prepared in 84.2% of cases. 27(15.8%) did not have chronologies available. Again this is part of the escalation policy and these cases are reviewed in the monthly management meetings.

4.7.10 In conclusion the Head of Safeguarding reports that now for any case where a concern is raised the process is that this is discussed in the monthly practice manager / Conference chair meeting. If this concern is not resolved it is escalated to the monthly Safeguarding / Service manager meeting. Any case with outstanding concerns over 8 weeks is escalated to the Heads of Service. The impact of this is that there is now a safe escalation policy in place on all child protection cases.

4.7.11 In respect of **the review of cases** every case where there has been a concern raised will be reviewed at the monthly Practice Manager/IRO meeting. Alongside this all cases where children have been subject to a plan for 18 months or more are also reviewed. Those concerns that are outstanding are escalated to the monthly Service Manager/Safeguarding Manager meetings. In April 41 cases were reviewed, in May 58, June 48 and in July 41.

The LSCB can therefore be reassured that all appropriate matters are receiving the correct level of management oversight.

4.7.12 The original action intended that reports be presented over a 12 month period so it is suggested the LSCB confirm this and ask that a progress report be presented to L&IG in December and a full update be presented to the LSCB in March 2015.

4.8 **ACTION.** ***The LSCB will establish a task and finish group to consider the introduction of a 'stop and review' process that can be called for by any professional at any time during the course of a Child Protection Plan. (By June 2014)***

4.*8.1* The Stop and Review process has been agreed and is now in the LSCB Escalation Policy, to be published and disseminated in September 2014. It has also been inserted into the CYPS Child Protection Conference Procedures and is now an embedded practice across the County.

4.8.2 It has been used three times since April 2014. On each occasion the need to implement the process was identified through the monthly Safeguarding manager / Service Manager meeting, as they felt the cases needed earlier intervention than previously planned due to the plans in place not apparently achieving the desired outcomes. In each case the plans were reviewed and amended which resulted in one reverting to a Child In Need Plan and the

other two remaining subject to Child Protection Plans, with one moving to the Public Law Outline and the other with more focus on a clearer assessment.

4.8.3 It is clear that the introduction of this process is and will continue to have the desired impact as without it the children in these cases would likely to have continued with the same Child Protection Plans, which were not effecting the positive change required or expected.

4.8.4 It is suggested the LSCB agree this action as 'complete'.

5. Effective Challenge - Learning 14.5 and 14.6

5.1 *For Child Protection Conferences to only include those professionals directly working with the family will deprive the Child Protection Conference of objective input by managers and specialists to help progress the case and reduce safeguarding risks of the children.*

All professionals have the responsibility to challenge inappropriate or ineffectual practice, which has become intransigent and is not protecting children. This does not solely apply to Child Protection Conferences and should include the need to escalate concerns to senior managers when necessary.

5.2 When considering this learning in January the LSCB acknowledged that challenge throughout the partnership to be a key factor in safeguarding and promoting the welfare of children. However, it recognised that this was not being consistently used to best effect and that as a consequence there was a need to embed consistency among partners to promote professional challenge and develop further mechanisms to resolve inter-agency differences. It recognised that there were three Local Area Safeguarding Groups across the County who meet on a quarterly basis to discuss local safeguarding practice and issues and that the LSCB had an escalation policy entitled 'Working together to resolve professional disputes'. However it acknowledged that in this particular case neither had an impact.

5.3 No remedial action had been taken prior to January so the following actions were agreed:

5.4 ACTION. ***The LSCB Planning Policy and Engagement Group will review, revise and re-publish new practice guidance on resolving professional disputes. This will include consideration of a method of mediation and will include a mechanism for senior managers to attend Child Protection Conferences when appropriate. The LSCB will co-ordinate an awareness raising campaign about the revised policy on re-launch. (By Sept 2014)***

5.4.1 Guidance has been reviewed, revised and agreed by the LSCB Policy, Practice and Engagement Group. The group agreed that the expectation would be that mediation via the LSCB only takes place after intervention and negotiation at a strategic manager level. The guidance was disseminated at the 3 day event held in early September and is available via the LSCB website.

5.4.2 An awareness campaign on the revisions to all practice guidance relating to the SCR is running through September to October 2014.

5.4.3 As this guidance has yet to be disseminated, there is no evidence of impact, although anecdotal evidence would indicate that there is a greater awareness of the guidance and that partner agencies are more aware.

5.4.4 It is suggested the LSCB agree this action as 'completed'.

5.5 **ACTION.** ***The LSCB will include a section in the annual Section 11 Children Act self assessment that requests agencies to report on their use and impact of the LSCB escalation policy. (By June 2014)***

5.5.1 Paul Nicholls, LSCB Professional Advisor Quality Assurance & Performance confirms that in June 2014 a new section was added to the joint Suffolk/Norfolk Section 11 Self Assessment. The standard requires that 'staff are aware of the LSCB Professional Disputes Policy and feel confident to use it where an issue is adversely affecting outcomes for a child or family'. Partners will be asked to outline how staff are made aware of the policy, provide examples of how it has been used and through those demonstrate the impact that the policy has had.

5.5.2 Since inclusion no Section 11 Audits have been completed but a number are planned to take place from November onwards.

5.5.3 Although technically this action is complete, in that the section has been included in the revised Section 11, no evidence has yet been collected to demonstrate an increase in usage of the policy and the impact that has had on practice. It is therefore recommended that the LSCB note the progress of this action and require a further progress report to address those issues in March 2015.

5.6 **ACTION.** ***The LSCB will lead a review of the role and function of Area Safeguarding Groups. This will ensure they are 'fit for purpose' and in particular have mechanisms to support and enhance multi agency challenge***. ***(By April 2014)***

5.6.1 Completing this action has been delayed for a number of reasons. They include: The frequency of meetings - Area Safeguarding Groups are held quarterly and initial discussions/consultations were required via an agenda

item at each group before the Task and Finish Groups were formed to inform an initial proposal; changes in personnel in the Safeguarding Service and within partner agencies, and difficulties in bringing together a multi-agency task and finish group during the Summer period.

5.6.2 Paul Nicholls, LSCB Professional Advisor Quality Assurance & Performance confirms that in August 2014 revised draft Terms of Reference (ToR) for Area Safeguarding Network meetings were agreed with the three CYPS County Safeguarding Managers and are now due to go before a group of LSCB multi-agency representatives to complete the consultation process. The revised ToR will ensure that the meetings maintain the focus on both strategic LSCB countywide issues and also local area safeguarding operational matters. A member of the LSCB Central Support Team will attend all meetings. The strategic agenda will be agreed in advance with partners to ensure consistency and will focus on national and local SCR updates, learning from local cases, policy and procedure changes and findings and recommendations from local audits. The local agenda will focus on sharing of good practice, resource and training issues and learning from case studies. This will allow multi agency partners the mechanism to share information, challenge partner's current practice and improve and learn. The meetings will be held quarterly with one of the meetings each year being a countywide multi agency seminar, held across area and focussing on the main issues identified in the preceding three meetings.

5.6.3 The revised format will ensure consistency across the county and provide the opportunity to embed learning and the sharing of good practice.

5.6.4 Although progress has now been made with this action no evidence has yet been collected to demonstrate whether the revised structures have or will have an impact on partner's ability and readiness to challenge when there are concerns about professional practice. It is therefore recommended that the LSCB note the progress of this action and require a further progress report to address those issues in March 2015.

6. Robust Management Oversight - Learning 14.7 and part of 14.2

6.1 *In demanding child protection cases, robust management oversight of the progress of the case is essential and should be shown to have a direct role and impact on the professional interventions*

6.2 The LSCB Response in January agreed that robust management oversight of cases is essential. It also recognised that financial pressures have necessarily resulted in a reduction but emphasised that through its Annual Report it had, over the last three years, urged partners to ensure that despite this, adequate management, skill and oversight remains within the system to mitigate increased risk during times of financially driven change.

6.3 The Response noted that the senior management in Lowestoft had been changed and strengthened in October 2012 and that as part of the ongoing SCC CYPS audit programme a 'Health Check' was undertaken between December 2012 and 2013. This health check has evidenced a clear need for improvements in practice mainly due to management and staff instability resulting in poor management oversight. An action plan was put in place to address this which was reviewed and checked following the events subject of this Review. The progress of the action plan has been overseen at Senior Director level during 2013. In addition it acknowledged that an Ofsted inspection of Child protection arrangements took place in June 2013 in which Lowestoft cases and management were included in their scrutiny. The overall judgement by Ofsted was that services were 'adequate'.

6.4 It was reported in January that as a result of the action taken in Lowestoft:

- The staff vacancy rate has been reduced to 6% (3 staff);
- 97% of children subject to Child Protection Plans are currently visited every 15 days in line with practice standards.
- The Public Law Outline tracking sheets in Lowestoft evidence that there has been no drift in Public Law Outline cases. A meeting with the judiciary in Lowestoft has confirmed cases are dealt with in a timely manner;
- In the last six months there has been a 61% reduction in the length of time children are subject to Child Protection Plans for over 18 months.
- There has been a reduction in caseloads overall and in particular for newly qualified social workers;
- From July 2013, managers in Lowestoft have audited 15 cases every month.
- A duty system has been put in place to ensure when there is staff sickness that statutory visits still take place within timescales.

6.5 The LSCB found this very reassuring but agreed that to ensure this level of performance was maintained that ***the LSCB requires a report in July 2014 from SCC CYPS evidencing that child protection practice conducted in the Lowestoft area continues to be consistently and appropriately subject to the appropriate levels of senior management oversight. The report will detail evidence to support such assurances including audits, caseload information, supervision compliance, staffing and consistency of management of cases*** **(By July 2014)**

6.5.1 In July 2014 the report from the Head of Safeguarding indicated that, for a variety of reasons, the good progress made in Lowestoft reported in the LSCB Response had not been maintained and that management intervention had been initiated to mitigate any developing risk. Clearly the PLO Tracking Sheets and monthly meeting previously reported help in this regard but staffing challenges have resulted in performance pressures.

Latest information suggests

- Although there are no social worker vacancies in Lowestoft this does not reflect the true position with regard available resource. There are 4 locums working in the 0 – 11 Team and of the remaining 12 permanent staff 6 are newly qualified social workers (just starting) and 6 are ASYE (just completing their first year). This affects their ability to hold cases thus putting pressure on others.

- Latest figures suggested that only 72% of children subject to subject to Child Protection Plans are currently visited every 15 days in line with practice standards. This sharp decline in performance has been investigated and it appears may be as a direct result of a locally introduced tracking system that has given a false picture. This has been confirmed through an audit of 71 children who are on a plan and it showed that 94.4% have been visited within the timescale stipulated in the plan. 4 cases (5.6%) were outside the required visiting time stipulated in the plan and these had been escalated to the monthly management meetings

- In the July report three Social Workers were reported as having caseloads of 48, 45 and 37, a significant rise from figures quoted in January 2014. This has now reduced considerably with one worker having a caseload of 32, another 30 and three workers with caseloads of 31. The remainder hold a lesser number of cases.

- Challenges with maintaining audit have previously been mentioned and although the precise number of cases audited by managers in Lowestoft is not known it is unlikely to be 15.

6.5.2 As a direct result of the supervisory figures coming to the attention of the Interim Head of Safeguarding immediate action was instigated at Lowestoft. This resulted in the review of all 0 to 11 cases, all Looked After Children cases and a sample of 12+ cases to ascertain the level of supervision and management oversight. This showed that;

- There was evidence of some staff not receiving regular supervision
- Supervision agreements were not in place on all staff files
- There was some evidence of Signs of safety being used but this needs to be improved
- Seeing yourself from the child's viewpoint was flagged as an area for improvement
- There was good evidence of risk management.

Overall the Service Manager was clear that they have no concerns about child safety following this audit. An immediate action plan has been put in place to remedy the identified short falls in supervision, which included on 2nd September both Practice Managers running a 30 minute session on supervision at their Team Meetings.

6.5.3 In his report contributing to this progress report David Jacobs, Interim Head of Specialist services reported that management oversight includes a range of strategies and systems to promote management awareness of; quality of practice (including application of SOSWB, partnership engagement with families and other agencies, and research awareness etc), supervisory oversight and decision making, and compliance with timescale /recording /data requirements etc.

In addition to formal supervision, current Strategies include;

- New "Orbit" Statutory Assessment timescales and progress monitoring just launched, giving "real time" data regarding open and closed assessments – current DC assess trackers to be reviewed (may release DC time to be applied more productively in assess content and progress)
- Public Law Outline/"Permanence" Tracker – recording progresses of all cases within PLO – and to be extended to include all LAC (systems praised by Ofsted inspections in other LAs as effective in assisting avoiding of case "drift")
- Child In Need (CIN) "tracker" spreadsheets, which include identifying compliance with visiting in accordance with CPPs, CIN visiting and CIN meetings etc
- Service Manager monthly performance Report (referred to previously, and being updated with assistance of Ann Goldsmith, Independent Consultant) –and providing data, e.g. on; assessment timescales, caseloads – including "throughput", care / CIN plan recording compliance, staffing resources, analysis of issues and strategies being

used. Trends will also be included in order to support insight into direction of travel in key areas.

- Weekly team and individual caseload reporting, provided centrally, highlighting exceptions above target numbers.
- Monthly PM/IRO and SM/SGM meetings – to review CP/LAC "concerns" as identified in conference and stat review processes.
- "stop and review" process
- Monthly team "dataset" reports which include a wide range of data to assist the monitoring of case progression
- **New** monthly meetings planned between Interim Head of Safeguarding and Interim Head of Specialist Services (in post since June), to review pressure areas in the county as indicated by above reporting systems.
- **New** system agreed with Legal Services to escalate cases to Interim Head of Specialist Services to review where legal advice encouraging court application is not acted upon by any team and its SM.

6.5.4 In addition David Jacobs reports that oversight of case management and progress is first provided by the first line supervisor`s (Practice Manager, and Senior Practitioner in some teams) supervision of the allocated practitioner. This is recorded within Carefirst. Compliance with the frequency of such supervisory oversight, and the quality of its content is evaluated within case audits undertaken within the county case audit programme. Evaluation of supervisory oversight is added to within the normal process of management and sometimes senior management (including EDS Operations management) involvement in case review and decision, as particular needs arise or complaints received.

6.5.5 As part of the structured CYPS Audit process Service Managers are required to audit a number of cases to assess management oversight. The most recent findings showed;

In June 2014 - 50 cases reviewed – 35 "Good", 11 "requires improvement" and 4 "inadequate"

July 2014 - 16 cases (awaiting more), 3 "Outstanding", 7 "Good", 5 "Requires improvement", 1 "inadequate".

The process includes a system of highlighting where deficits are found and identifying actions to address them. It has to be noted that the above findings do not relate to Lowestoft cases where audits were not undertaken due to a period of management shortage and change and considerable locum changes meaning priority had to be given to case working and management cover, over auditing.

6.5.6 The quarterly meetings initiated in Lowestoft following this review still take place but due to structural change are now attended by the Assistant Director Specialist and Integrated Services, newly appointed Interim Head of Specialist services, Interim Head of Safeguarding, County Safeguarding Manager and Service Manager for that area. The key focus of this meeting from August will be;

CP LAC and CIN numbers
Visits for CP and LAC
Caseloads and vacancies
Supervision
CP Plans 18 months or more
Audit findings
Assessment timescales
Level of Chairs observation
Step up and Step Down figures
Review of the Lowestoft Action Plan

6.5.7 It is suggested that due to the contrasting and to some extend conflicting information about how the Lowestoft Area is performing that this update be noted, the LSCB seek reassurance that performance across the Lowestoft area is being closely monitored and action to address any weaknesses and a further update required in March 2015.

7. Mechanism for Professional Consultation - Learning 14.8

7.1 *To generate the appropriate response and relevant assessment of parents when there are concerns about possible adult mental health issues will prove to be very difficult when the parent does not see the need for any such assessment and is avoidant of any assessment activity focussed upon mental health. It nevertheless must remain on the agenda for multi-agency discussions in consideration of any changing family circumstances, and whether this might enable pertinent mental health assessments to be newly progressed and offered to the parent in question.*

7.2 The LSCB Response in January recognised that the issue and potential impact of an adult's mental health and wellbeing on their children is a significant factor in ensuring their safety and wellbeing. It noted that it had current practice guidance entitled 'Working with Hostile, Non Co-operative Clients and those who use Superficial/Disguised Compliance within the Context of Safeguarding Children' and acknowledged that this practice guidance should be the subject of review as outlined in paragraph 2.3 above. It concluded that the review should also include the development of a mechanism for professional consultation when there are professional

concerns as to mental and emotional wellbeing of a parent, but no clear diagnosis.

7.3 There were no additional actions set out by the LSCB.

8. Chronologies and background information – Learning 14.10

8.1 *Background information of a parent's own childhood is essential to understanding their own parenting capacity, and if this information is not collected and shared among professionals, it will limit the accuracy of any parenting assessment.*

8.2 In January the LSCB agreed that background information is essential in order to make informed decisions and noted there is a shared multi agency commitment to ensure relevant information is available for inclusion in assessments and other child protection processes. However it recognised that in this case the learning events indicated that the failure to collect and/or record background information was specific to this case and not a reflection of a systemic problem. Nevertheless, the LSCB required further assurance

8.3 **ACTION. The LSCB will satisfy itself that the Statutory Assessment Framework and supporting Information Technology systems include a checking prompt to ensure that background information is included as part of any assessment analysis. (By February 2014)**

8.3.1 The Statutory Assessment Framework guidance gives clear instruction that there are several sections to the assessment where parental/carer strengths and issues that may have implications for effective parenting are recorded. The guidance outlines that Social Workers should record information on the parent/carer's ability to meet the child's needs in line with Signs of Safety and Wellbeing practice i.e. 'what are we worried about'. The Social worker must also give consideration to whether a referral to other agencies is required. 'Signs of Safety and Wellbeing' emphasises the need to give equal weight to 'family knowledge and wisdom' when considering alongside that of professional knowledge and expertise. Social Workers must remember "absent" parents and new partners in all of their assessments, detailing their role in the child's life and what this means to the child. Effort should be made to contact "absent" parents (often fathers) and gain their views and information about their relationship with the child. Consideration should be given to; the family history (including parents`/carers` own history), wider family impact or support, housing or accommodation issues, employment and income, the family's community and social integration and any resources and resilience support in the community.

8.3.2 Adjustments and updates have been made to the Carefirst System (SCC CYPS IT system to support their work) to support the revised Statutory Assessment and ensure all elements of the assessment are undertaken and recorded.

8.3.3 It is suggested that additional assurance be sought that the checking prompt in the IT recording system is proving to be effective in ensuring that background information is included in any assessment is required as part of the update report previously commissioned for the December LSCB meeting.

8.4 **ACTION. The LSCB will disseminate information from this case and ensure that the sharing of learning outcomes include particular emphasis on the importance of background information in assessments. (By Spring 2014)**

8.4.1 Suffolk LSCB recognises the importance of learning and improving through sharing experiences across the partnership. Therefore a range of learning and themes from local and national Serious Case Reviews and Learning templates are made available to a wide network via the LSCB website, through electronic 'e-briefings' and through information shared within sub-groups.

8.4.2 Learning from this review was disseminated throughout partner organisations, via the website and through five multi-agency presentation events led by the LSCB support team and held at locations across the county. In addition a number of other multi and single agency learning events and presentations have taken place to address the training needs identified. 73 professionals attended the multi-agency presentation events. Feedback from agencies would indicate approximate numbers in excess of 300 staff of LSCB partner agencies have been briefed specifically on the lessons learned from this SCR. In addition, the Safeguarding in Education Team have incorporated lessons from the SCR into their safeguarding training delivered to the 275 designated leads in schools.

8.4.3 The LSCB has procedures in place that direct practitioners to ensure that assessments **must** include background information on the child/children's parents with an analysis of that information in relation to the risk it may present. Management mechanisms have been implemented to provide a checking process that ensures assessments include full background information and regular monitoring of compliance with the provision of full and accurate chronologies to Child Protection Conferences.

8.4.4 Revision of key LSCB policies on Escalation, Working with Hostile and Evasive families and the development of a fact sheet on the Public Law Outline will be disseminated widely between September and December 2014.

8.4.5 It is suggested the LSCB agree this action as 'completed'.

8.5 **ACTION. The report from SCC CYPS Head of Safeguarding referred to in paragraph 4.6 will include information on compliance with the provision of full and accurate chronologies for Child Protection Conferences. (By July 2014)**

8.5.1 An update is provided at section 4.7.9 and in line with the proposal at the end of that section it is suggested the LSCB receive a further report on this issue in March 2015.

9. Effective Working Relationships – Learning 14.11 and 14.12

9.1 *Drift of the Public Law Outline process must be avoided by strong management oversight and via an effective working relationship between CYPS and legal services. This can only be achieved if there is a shared understanding and clarity about the separate roles, responsibilities and accountability for decision making.*

If there is a shared understanding by non CYPS agencies of legal processes instigated for children, then they are more able to contribute and challenge the process when appropriate, as part of partnership working

9.2 The LSCB Response noted that from spring 2013 monthly meetings between CYPS Senior Management and Senior Legal Management had taken place to bring the services closer in addressing together challenges they both face in child protection and the revised Public Law Outline (PLO). This included cases highlighted through the PLO case tracking system and the recently strengthened escalation process to Heads of Service of cases causing concern within the legal process. In addition in January 2014 SCC introduced quarterly meetings between the Heads of Corporate Parenting, Legal Services, Safeguarding and the Lead Lawyer to maintain a strategic overview of current practice and future developments. SCC also reported there had been a formal review of the PLO process and as a result outcomes from the legal process are shared with partner agencies through the Child Protection Conference and ongoing Core Groups.

9.3 The immediate impact of measures taken as a result of this action was that in Lowestoft the Public Law Outline tracking sheets evidenced that there had been no drift in Public Law Outline cases. A meeting with the judiciary in

Lowestoft has confirmed cases are being dealt with in a timely manner. Despite this progress the LSCB required two further actions.

9.4 **ACTION. In July 2014 SCC Legal Services are required to provide a report to the LSCB evidencing progress made on eliminating drift through the regular meetings and introduction of the PLO case tracking system. (By July 2014)**

9.4.1 A report was presented to the LSCB meeting of 14th July 2014. It confirmed that since January both the Quarterly and monthly meetings referred to above have continued, as has the PLO tracking system and that all three are now embedded in practice. On appointment of the Interim Head of Specialist Services they have now joined this quarterly meeting. The report confirmed that between April and June 45 cases across Suffolk were tracked with only 1 having a reported delay, which appeared to be as a result of changes made to the Assessment Plan.

9.4.2 The impact of introducing these measures has been to ensure there is the correct level of management oversight, from both CYPS and Legal services, of cases where there is risk of 'drift' and ensuring that this does not occur. For example at the last meeting (27th August) 5 cases were discussed and decisions made with regards actions required and lessons learnt. Another added value of these meetings is that now Legal are included in the County Resources Panel (decision making vehicle for agreeing to issue legal proceedings and agree placements for Looked After Children) decisions, minutes are distributed to all lawyers which eliminates potential drift in cases. Where drift is identified immediate action is taken. Also at this meeting it was identified that staff in Lowestoft appear to be seeking legal advice prematurely and then not always acted on it. Immediate action has been taken to remedy this.

9.4.3 It is recommended the LSCB sign off this action as 'completed'.

9.5 **ACTION. The LSCB requires SCC Workforce Development to review Levels 2 & 3 multi agency training provision to ensure it provides an understanding of formal legal processes associated with Child Protection, in particular PLO. The result of this should be reported by July 2014 to the LSCB Planning, Policy and Engagement Group.**

9.5.1 As reported in paragraph 2.4.1 Workforce Development confirm that an explanation of Public Law Outline has been incorporated into training. There has also been a powerpoint presentation prepared for use by partners and this is available on the LSCB website.

9.5.2 It is suggested the LSCB agree this action as 'completed'.

10. Additional LSCB Action

10.1 **ACTION. The LSCB will disseminate information from this case through a series of seminar events in spring 2014. It will work with SCC Workforce Development Team to ensure the lessons are incorporated into Level 2/3 LSCB endorsed safeguarding training and training for newly qualified social workers.**

10.1.1 Paragraph 8.4 above outlines that learning from this review was disseminated throughout partner organisations, via the website and through five multi-agency presentation events led by the LSCB support team and run across the county. In addition a number of additional multi and single agency learning events and presentations have taken place to address the training needs identified. 73 professionals attended the multi-agency presentation events. Feedback from agencies would indicate approximate numbers in excess of 300 members of LSCB partner agencies have been briefed specifically on the lessons learned from the SCR. In addition, the Safeguarding in Education Team have incorporated lessons from the SCR into their safeguarding training delivered to 275 designated leads in schools. CYPS also confirm that the SCR Report and subsequent learning was disseminated across the service in Management Teams, Practitioner Workshops, Team Meetings, Development days and 1:1 supervision and peer supervision sessions. To date the information has been disseminated to approximately 600 members of staff across specialist, integrated and CYP health personnel. There is an ongoing plan for continued dissemination to a further 250 staff in the next few months.

10.1.2 Workforce Development have revised level 2 and 3 multi-agency training and this has been evaluated and endorsed by the LSCB Professional Advisor for Performance and Quality Assurance.

10.1.3 It is suggested the Board agree this action as ‘complete’

11. Single Agency Actions arising from completion of their Individual Management Reviews

11.1 As part of the Serious Case Review process each of the agencies that had contact with and/or involvement with Family ‘A’ were required to produce an Individual Management Review for consideration by the Review Team and Overview Writer. Some of the issues and matters arising from those reviews fed through into the published review but not all, as they may have been specific to the agency themselves.

11.3 In June all agencies were written to and asked to provide details of those individual matters, the actions that arose, the results of those actions and the impact that those actions have had. The following provides a summary of the responses.

11.4 **Access Community Trust**

No Actions put in place

11.5 **CAFCASS**

'Within the chronology submitted by Cafcass, the author found the Children's Guardian to have acted in an appropriate manner, and in accordance with Cafcass policies and procedures. As a result of this, no action plans were put into place by Cafcass following from this Serious Case Review, nor were any actions identified for Cafcass within the LSCB multi-agency plan. Therefore I am unable to provide you with a specific update; however CAFCASS has a clear learning structure on how as an organisation, we learn from Serious Case Reviews'

11.6 **Ipswich and East Suffolk CCG and West Suffolk CCG**
Actions in line with the LSCB Multi Agency Audit Plan

Additional Actions:

- Norfolk and Suffolk NHS Foundation Trust to work in partnership with LSCB PPE Group to revise current policy on working with hard to reach and avoidant families.
- All health care organisations to cascade out to their staff the revised LSCB policy on working with hard to reach and avoidant families and provide assurance to the CCGs that that has been done through the LSCB health subgroup.
- All safeguarding children leads within each health organisations will review their training packages they provide to ensure it adequately covers good practice with hard to reach and avoidant families.
- All safeguarding children leads within each health organisation to be familiar with the LSCB policy on working with hard to reach and avoidant families and any up to date research on this field to enhance the supervision they provide to front line staff.

- All health organisations to review their safeguarding children and safeguarding children supervision policies to ensure these cover appropriate escalation of cases and inclusion of the requirement to have safeguarding children supervision provided by a supervisor with experience and training in safeguarding children supervision.

- The CCG to facilitate a bespoke NSPCC safeguarding children supervision training for the safeguarding children health leads. Each provider to ensure they enable their relevant staff to attend as appropriate

- All health safeguarding children supervisors to review Child protection plans with front line practitioners in supervision where concerns relating to drift have been raised.

- Where appropriate Named Nurses and Named Midwives should consider attending child protection conferences with front line practitioners where the management of the case has become problematic to support the effective review of the case and the support the health practitioner involved.

- All health care organisations to cascade out to their staff the revised LSCB policy on resolving professional disputes and provide assurance to the CCGs that that has been done through the LSCB health sub-group

- All safeguarding children leads within each health organisations will review their training packages they provide to ensure it adequately covers good practice resolving professional disputes.

- All safeguarding children leads within each health organisation to be familiar with the LSCB policy on resolving professional disputes and professional challenge to enhance the supervision they provide to front line staff.

- All health organisations to ensure accurate recording in the child's health records that includes reference to any relevant background information that impact in the child's health and development.
- All health organisations to ensure all relevant information including any relevant background information is included in any child protection referrals to enable accurate assessment of need and risk. This must include all relevant information on parenting capacity, family and environment and child's developmental and health needs.
- Where a child has been referred for a paediatric medical assessment the reviewing doctor must take reasonable steps to ensure they are aware of any relevant family's back ground and any existing safeguarding concerns prior to the assessment.

- All of the above to be monitored by a robust annual audit of children's records where there are safeguarding concerns which must be included in the safeguarding team's annual audit plan.

- All Health Safeguarding Children Supervisors to be aware of PLO to support front line staff in their understanding of this legal process.

- The Designated Professionals will provide all health organisations that deliver level 3 safeguarding children training with a slide that gives a brief explanation of the PLO process to be included in this training.

11.7 **East Coast Community Healthcare**

ECCH main actions were in line with the LSCB Multi Agency Action Plan. Additional actions:

- All health organisations that provide health visiting services or provide the assessment of postnatal depression to ensure these assessments are in line with Nice Guidance: Antenatal and Postnatal Mental Health 2007. Completed June 2014.

- Where a child has received a suspicious injury any referral for assessment of the injury must follow the LSCB Joint Protocol for Child Protection Paediatric Assessment and Forensic Medical Examination. Implemented with immediate effect.

11.8 **James Paget Hospital**

Actions in line with the LSCB Multi Agency Action Plan (working with avoidant families, refreshing staff on use of safeguarding supervision and escalation of cases, awareness of PLO).

Additional actions:

- Staff training around the emotional impact of neglect and the importance of gathering and recording the child's view (training and case auditing). Completed April 2014.

- Faltering growth guidelines developed and disseminated in 2013.

11.9 **Suffolk County Council Children and Young People's Services**

All actions were incorporated in the LSCB Multi Agency Action Plan.

11.10 **Suffolk County Council Legal:**

Additional actions:

- Our internal active audit system flags up and major concerns with a case and the risk management of the case (not in the report)

- Legal to have access to the tracking system implemented by Children's Services

11.11 **Norfolk and Suffolk NHS Foundation Trust**

Actions in line with the LSCB Multi Agency Action Plan (working with avoidant families, ensuring safeguarding is addressed through robust supervision and staff are supported to escalate cases).

Additional actions:

- Staff training to include a focus on Neglect and learning from SCRs.

11.12 **Waveney District Council**

Three practice points relating to homeless families:

- If the family is accepted into temporary accommodation there will be a generic needs assessment carried out at the point of sign up which will include identifying any safeguarding/welfare issues. Looking to further develop a protocol to use this to trigger referrals through to CYPS - Suffolk Family Focus or Floating Support.

- The homeless application form also has a section relating to the householders permission for the Council to contact CYPS.

- If there is a welfare/safeguarding issue as well as threatened homelessness the Council will make referrals for support to Coppice Court/Haven Court (Flagship).

11.13 **Suffolk Constabulary**

No additional actions to those identified in the LSCB Multi Agency Plan. Self-referral of this case was made to the Independent Police Complaints Commission who found that officers would not have been able to foresee what happened and did not proceed to investigate.

12 Individual Agency Learning Models to identify learning

12.1 Following the review process questions were raised about the systems and structures in place within individual agencies to enable cases where there may be learning to be identified and notified to the LSCB. Letters were sent to each partner agency seeking reassurance that all had systems in place that would identify appropriate cases.

12.2 The LSCB Case Review Panel agreed on the meeting held on the 16th June that a report would be produced on partner agency's internal learning and improvement arrangements.

Twenty organisations were contacted and below is an overview of the responses received to the questions asked;

12.2.1 Question - Does your organisation have an internal mechanism for flagging up Serious or Untoward Cases regarding safeguarding children and identifying any opportunities for lessons to be learnt? If so, what is the process?

In all cases, organisations who responded to the first question confirmed that they have an internal mechanism for highlighting safeguarding issues. In most cases this involves escalation to a senior manager who will review the case and arrange for an investigation, proportionate to the case, to proceed. In a few agencies where safeguarding investigations are not in the context of the agency's work this would involve reporting to Social Care and requesting feedback and then utilising feedback to learn.

12.2.3 Question - How does your organisation ensure that lessons learnt for Serious or Untoward Cases regarding safeguarding children are disseminated to all internal staff members?

Dissemination of lessons to internal staff members is undertaken in every organisation who responded, albeit in a variety of fora and utilising different methods.

These include: Via Staff Meetings, Practitioner Workshops, Commissioned Training either internally or via external Trainers, intranet, reports to Boards. E-learning or briefings and via changes to policies and procedures.

12.2.4 Question - How does your organisation ensure that the impact of internal learning from Serious or Untoward Cases regarding safeguarding children is measured?

Measuring impact of internal learning appears to be an area for development across the partnership. Current measures include;

- *Audit and thematic review work to look at any similarities in serious incidents and the success of embedding new practices;*
- *commissioned research;*
- *Trend analysis;*
- *Appraisal;*
- *1:1 supervision*
- *Training efficacy audit work;*
- *Reviews of learning point recommendations at agreed intervals;*

While most organisations have some form of measure in place, measuring and accurately recording impact appears to be a challenge across the partnership and it may be appropriate to list and share all the methods utilised or suggested by partners, potentially with the contact details of the P&QA lead in each organisation, in order there can be dialogue between agencies and the sharing of useful impact measuring resources In conclusion, the

responses received from partners should give reassurance to the LSCB that there is a reasonably consistent approach within individual partner agencies to identifying, referring and learning from serious or untoward incidents regarding safeguarding across the partnership.

However, a culture should be promoted that shares learning, best practice and solutions across the partnership in order to promote maximum impact across the partnership.