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Children and Families Overview and Scrutiny Panel Wednesday, 13 September 2017, County Hall, Worcester - 10.00 am

Minutes

Present:

Mrs F M Oborski (Chairman), Mrs J A Potter (Vice Chairman), Ms P Agar, Ms R L Dent, Ms P A Hill, Mr S M Mackay, Ms T L Onslow and Ms S A Webb

Also attended:

Derek Benson, Independent Chairman, Worcestershire Safeguarding Children's Board
Mr A C Roberts, Cabinet Member with Responsibility for Children and Families
Mrs E B Tucker, Group Leader 2017 Group
Jane Stanley, Worcestershire Healthwatch

Sue Haddon, Sheena Jones (Democratic Governance and Scrutiny Manager) and Samantha Morris (Overview and Scrutiny Officer)

Available Papers

The members had before them:

A. The Agenda papers (previously circulated);
B. The Minutes of the Meeting held on 14 August 2017 (previously circulated).

(A copy of document A will be attached to the signed Minutes).

285 Apologies and Welcome

Apologies were received from Mr B Allbut and Mr B Banks.

286 Declaration of Interest and of any Party Whip

None.

287 Public Participation

None.

288 Confirmation of the Minutes of the Previous Meeting

The Minutes of the Meeting held on 14 August 2017 were agreed as a correct record and signed by the Chairman.

289 Worcestershire Safeguarding Children Board Annual Report 2016-17

Derek Benson, Independent Chairman of the Worcestershire Safeguarding Children Board (WSCB) attended the meeting to present the Worcestershire Safeguarding Children Board Annual Report 2016-17.

Since the report had been written Essex County Council had been formally appointed as Worcestershire's Improvement Partner to develop a programme of work to provide support and challenge to service improvement. Mr Benson pointed out that changes made to services since March 2017 were not included in the report.

In August 2016, the Independent Chairman informed the Panel that WSCB could not be assured of the effectiveness of local arrangements in respect of children in the child protection system. The quality and consistency of frontline basic practice needed improvement and more work was required in particular areas to ensure children were safe in Worcestershire.

During 2016/17 WSCB focused on:

- Healthy relationships and Child Sexual Exploitation (CSE)
- Early Help
- Integrated Family Front Door (FFD) and Thresholds
- Young people at the point of transition (with a specific focus on sexual exploitation)
- Children with disabilities
- Strengthening of the Board's Learning and Improvement Framework

By the end of March 2017, the Board had fully implemented its two year Child Sexual Exploitation Strategy 2015-17 now replaced by a refreshed Strategy for 2017-19. In the main, partner agencies continued to demonstrate a high level of engagement in development of the strategies and in implementation of the action plans. However in its review of the Local Safeguarding Board in October 2016 Ofsted noted that the number of changes in strategic leads, namely Children's Social Care and West Mercia Police, had impacted on pace in the area of CSE. The Board had now been provided with assurance that there would be greater consistency of personnel going forward.

A specific piece of work undertaken by the Board during the year was the implementation of the 'Whole School Approach to Healthy Relationships' framework and the Board would continue to seek assurance from schools

regarding embedding of the framework and its impact. A self-assessment audit undertaken during the year indicated that the majority of agencies were meeting the CSE standards referenced, but where this was not the case, action plans were in place to address any deficits. Whilst CSE remained a priority, it wasn't yet possible for the Board to be fully assured about the ability of the system to respond robustly and consistently to CSE concerns in Worcestershire.

Throughout the year, the Board monitored the early help offer in Worcestershire, paying particular attention to feedback from practitioners who had continued to express confusion about this and the pathway for accessing early support for children and families. Targeted interventions by commissioned early help providers continued to receive positive evaluations with low levels of re-referrals, albeit this related to the much smaller cohort of children and families than those who needed to access early help support from universal services. The number of recorded Early Help Assessments significantly dropped throughout 2016/17, whilst the number of referrals to the FFD continued to rise. There remained questions about: the capacity of commissioned services to meet demand, the role of universal services in delivery of early help across the wider partnership and the inability of the system to effectively measure early help activity. The Board therefore concluded that there remained serious questions about the effectiveness of the local early help arrangements.

This year had continued to see further pressure on the Children's Social Care system with increases in referrals, numbers of looked after children and numbers of children with child protection plans. Throughout the year the Board received updates on the move to create a single 'front door' to manage all contacts and referrals to Children's Social Care. Following their inspection in October 2016 Ofsted inspectors expressed concern about decision making and management oversight in the FFD. Inspectors also expressed concern that referring agencies were not routinely using the Levels of Need (Thresholds) Guidance leading to a high volume of inappropriate referrals and thresholds were not always being applied consistently during the daily triage process. The Board was already aware that the Levels of Need (Thresholds) guidance did not adequately address the early help pathway and that this was a gap. The Levels of Need (Thresholds) Guidance had since been significantly redrafted and would be reviewed again

during 2017/18 to reflect the early help pathway when approved by the Board.

The Ofsted Inspection had rated services for children and young people in Worcestershire an overall grading of inadequate. The Board had been sighted on the Local Authority Children's Social Care Service Improvement Plan (SIP) which set out how the required improvements would be achieved. The Board would continue to receive updates from the Director of Children's Services and the WSCB Independent Chairman who sits on the Service Improvement Board.

In last year's annual report the Board identified specific risks in relation to:

a) Completion within time scale of return interviews when children go missing (this has improved in that 48% of return interviews are now completed within time scale, however this still needed to improve and the Board's own audit of return interviews suggested that the quality of interviews was variable)
b) Waiting times for treatment from CAMHS (this had improved with wait times and numbers of children on waiting lists both having reduced in 2016/17)
c) Completion rates for Looked After Children (LAC) health reviews (the percentage of looked after children with an up to date health assessment had decreased this year from 72% to 62%)

Whilst some improvements had been noted during the year, performance in other areas of practice had declined. The Board was sighted on the Local Authority Children's Services Service Improvement Plan dashboard and would continue to monitor performance against targets over the coming year as part of its scrutiny role.

Six cases were presented during the year for consideration of a Serious Case Review but none met the threshold, decisions all subsequently endorsed by Ofsted. One reflective case review was commissioned and presented to the Board in March 2017. Key messages from learning would be communicated to the workforce during 2017/18.

During the year the Child Death Overview Panel in Worcestershire reviewed 36 deaths and noted that modifiable factors were present in 15 of them. Cumulative data in respect of babies whose deaths had

been classified as Sudden Infant Death Syndrome (SIDS) suggested that parental smoking and co-sleeping were often significant factors. An audit undertaken in February 2017 of babies born between November and December 2016 found that in all cases a safer sleeping risk assessment form had been completed with parents and where risks had been identified risk management plans were evident in 80% of cases which provided some assurance. In the deaths of unborn or extremely young babies factors such as maternal obesity, smoking, alcohol and other environmental factors were often present in some combination.

The Board was pleased to note some evidence of practice improvements from its repeat Multi Agency Case File Audits (MACFAs), however multi-agency practice was not yet found to be consistently good and young people were not yet routinely being screened for risk of sexual exploitation.

Last year's annual report noted that the Board's bi-annual Section 11 Audit indicated good compliance by partner agencies with their safeguarding duties and a strong commitment across the partnership to safeguarding children. In September 2016 a dip sample was undertaken of agencies' ability to provide evidence to support their reported position in respect of using service user feedback to develop services. It was found that some original self-assessments had been over-optimistic and so in future Section 11 Audits the Board would request supportive evidence as part of the original audit process.

The Board concluded that at a strategic level there was a strong commitment to safeguarding children in Worcestershire. It also received assurances that safeguarding arrangements were in place in most key agencies; however systemic failings in Children's Social Care were leaving children and young people vulnerable to harm.

Whilst demand for services continued to grow, further assurance was required as to the effectiveness of the wider early help offer and of practitioners' understanding of their own agency's role in providing early help to the families with whom they work. The Board also needed to be assured that practitioners understood the thresholds for accessing statutory services from Children's Social Care. The Board had a key role to play in supporting practitioners to develop their understanding of early help and thresholds and both would be priorities in the coming

year.

As of the end of March 2017 the Board had received assurance that strategies were in place to improve frontline practice, however it couldn't yet be assured about the impact of those and therefore the child protection system remained a risk. The Board recognised the scale and challenge facing the Local Authority and remained committed to working with all partners to bring about the necessary changes required to improve outcomes for children in Worcestershire.

During the discussion, the following points were noted:

- In response to the suggestion that that child protection should be listed as one of the key priorities for the WSCB, the Panel were advised that as child protection was integral to everything that the WSCB did, it hadn't been listed as a priority. However, in light of the suggestion this would now be considered
- The WSCB had been concerned about the number of changes in strategic leads, namely Children's Social Care and West Mercia Police, and how this had impacted on pace of progress in the area of CSE. The Panel were reassured that since writing the Report that assurance had been given to the Board that there would be greater consistency of personnel going forward
- The Board monitored the early help offer by encouraging, constructively challenging and scrutinising partners. It was also responsible for publishing threshold guidance
- One of the points that the WSCB had picked up was that there was confusion about the early help offer, this it was suggested was for various reasons but it was important to understand that 'the system' wasn't going to meet every need and children's social care didn't do everything. It was important that the resources available across partners were put to the best use
- Although the Panel couldn't be reassured that early help service levels were consistent across the County, the point was made that a different type of service didn't automatically equate to an inadequate service
- The Report highlighted that six cases were presented during the year for consideration of a Serious Case Review but that none met the threshold. The Panel were advised that there was strict criteria for meeting the thresholds of a

Serious Case Review and each referral was considered on a case by case basis

- There had been some evidence of practice improvements from repeat Multi Agency Case File Audits (MACFAs), however multi-agency practice was not yet found to be consistently good and young people were not yet routinely being screened for risk of sexual exploitation. The Panel were advised that work was ongoing to improve practice
- Although all partners were under pressure and changes to Local Safeguarding Boards were imminent, there was a sense of 'being in it together'. It was crucial for the WSCB to understand the early help offer and work with partners to ensure clarity around the threshold criteria
- The Ofsted Report had highlighted that the WSCB interface with the Family Justice Board and the Corporate Parenting Board still needed to be formalised. As a result there was now a Service Level Agreement in place so that each organisation could understand the work of the other
- In terms of the WSCB having access to all of the information it needed about children at risk of sexual exploitation, the Police were reviewing the Worcestershire profile and then adding information from other agencies to get a full picture
- In order to evidence that staff training was changing behaviours, the WSCB were challenging partners in a more robust way by asking them to demonstrate the impact of training by reporting back to Board and providing Action Plans
- To ensure that the voice of education was being heard, there was a representative from education on the WSCB
- Guidance for Local Safeguarding Boards as a result of the Wood Review was awaited and imminent
- It was confirmed that schools had been asked to use the Healthy Relationships Framework; the Board were planning to follow this up to seek assurances that this had been adopted
- The Panel were concerned about the lack of a representative for schools in the FFD triage process, it was confirmed that recruitment to this position was in the process of being finalised
- In order to reflect the change in structure, gaps in

the system and include the FFD, the Levels of Need Thresholds had been republished

- As a result of the Worcestershire Acute Hospitals NHS inspection by the Care Quality Commission in November 2016, the Board were assured in March 2017 that an electronic alert system had replaced the previous paper system for flagging children who were subject to a Child Protection Plan when they presented at hospital – this was work in progress and the Board were waiting to see if the process was effective
- The WSCB evidence base for monitoring the effectiveness of safeguarding arrangements in Worcestershire for children and young people included a combination of quantitative data, qualitative evidence, the voice of the child and the voice of the practitioner. It was however noted that the Voice of the Child was a continual challenge and wasn't as good as it could be
- The point was emphasised that where children and young people had contributed, it was very important to feed back to them about how their comments had been considered
- The Section 11 Audits now required supportive evidence as part of the process, which would take the form of a focus on specific areas service user feedback and dip samples
- In response to the concern about the number of children missing from education who were not legitimately being home educated but were avoiding education, the Independent Chairman of the WSCB advised that this concern was on the WSCB radar had been escalated regionally and nationally and that there was a need to be professionally vigilant of those families avoiding contact with professionals
- There were 4 main WSCB meetings per year and it was noted that that the attendance of some partners was poor and in a couple of instances non-existent – this was an area that the Board was following up to encourage attendance or understand the reasons for poor and non-attendance
- The point was made that it was very important for partners to share data appropriately and that Data Protection was not a reason for not sharing data.

The Panel requested:

- Comparative data relating to the:
  - number of recorded Early help

assessments and referrals to the FFD given that the number of recorded Early Help Assessments significantly dropped throughout 2016/17, whilst the number of referrals to the FFD continued to rise
    - waiting times for treatment from CAMHS and numbers of children on waiting lists
    - Completion within time scale of return interviews when children go missing
    - % referrals to the FFD that were inappropriate
- WSCB Action Plan and the WSCB Business Plan
- The definition of the threshold for carrying out a Serious Case Review
- Children with Disabilities Report due to be presented to WSCB in 2017/17 about the detailed findings about safeguarding arrangements for these children
- The reasons why 29% of respondents in the S11 Audit were not happy with the response from the FFD.

The Chairman thanked everyone for attending the meeting; she advised the Panel that there would need to be more meetings of the Panel in order to carry out an effective scrutiny role effectively in relation to the changes to children's social care stemming from the Ofsted Inspection.

The meeting ended at 12.05 pm

Chairman …….