Cheshire East
Children and Young People's Improvement Plan
to meet the Ofsted Recommendations

Creating a great place to be young

Improvement Action Plan Monitoring March 2016

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Embedding listening to and acting on the voice of children and young people throughout services

15. Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice.

Background to the recommendation:

- Analysis of complaints did not consistently result in effective action to improve practice.
- Recommendations from complaints did not sufficiently explore the underlying issues, and did not result in a reduction to the number of complaints received.

Activity, current position and impact: A learning action plan has been developed to address the themes from complaints and is presented and agreed at Service Managers' meetings. Progress against this is tracked and monitored to ensure effective action is taken.

29 complaints to children's social care were received in quarter 4. The vast majority of formal complaints (and other more informal comments/ feedback) are from parents. Only 5 of the complaints received in quarters 3 and 4 were from children and young people. The number of complaints received has remained fairly stable over the past 2 years.

The mains themes from complaints are:

- poor communication, including phone calls not being returned, minutes of meetings and copies of assessments not being sent out.
- Attitude, conduct and comments from staff
- Factual errors and inaccuracies in reports or information given
- Delays in receiving reports, assessments, or minutes, or in arranging placements
- Meetings being cancelled at short notice.

The theme from children and young people's complaints is poor communication.

These themes are consistent over time and reflect that our practice requires improvement. Practice reminders have been sent to social workers regarding the importance of good, timely communication. Action has been taken appropriately regarding professional conduct through individual supervision and line management. Service and senior managers continue to reinforce the standards expected, and challenge poor performance at Practice Challenge Sessions. Good practice is also celebrated at Practice and Performance Workshops to ensure staff recognise the hallmarks of good practice and the impact this has on children, young people and families. Action has and is being taken to improve frontline practice, such as developing a core training offer for social workers and managers, making the child's record system more user friendly and making social workers more accountable and answerable to their own performance through Performance Challenge Sessions. These actions are all discussed in more detail in later sections.

The number of compliments received this year has increased from 42 in 2014-15 to 61 in 2015-16 which is very positive. As at 8th April 2016, 20 out of 25 complaints had been resolved and closed at Stage 1, which is positive as this indicates that the

complainant was satisfied with our response and that they felt they had been listened to. Work is currently ongoing with the other 5, including meetings, to try and resolve these at Stage 1. None have yet been escalated to Stage 2 which is a positive step.

We recognise that we need to develop and embed a positive, responsive culture that puts children and young people first across all of the children's workforce. There is a plan in place on how we will put this into action, an overview of which is given in the next steps.

Themes from compliments and complaints are communicated to staff through Practice and Performance Workshops. Engagement with staff on changes to practice as a result of findings from complaints is done through these workshops or the Practice Champions Group. Changes to policy has been made in response to complaints, such as the Children with Disabilities Policy which was developed in response to parents and carers complaints that they were unclear on the process for assessments for children and young people with disabilities.

Children, young people, parents and carers' views are actively sought so that they can inform service planning. Children and young people, parents and carers are invited to take part in the children in need (CiN) and CP feedback survey, which is completed at the last core group meeting as cases are closed to children's social care to ensure a good level of responses. The results of this survey have been very positive; the survey showed that 88% families felt that the social workers' explanation for why they had got in touch with them was "very clear", and over 90% agreed or strongly agreed that the allocated social worker was easy to talk to, listen to their views and understood their situation. When asked about the reliability of their social worker, 98% were reliable or very reliable at returning calls, 95% were reliable or very reliable at doing what they said they would do and 88% were reliable or very reliable at turning up on time. The learning points from this survey were that while most families felt supported, some felt that communication could sometimes be better and that everyone should get a copy of the assessment, which echoes the feedback through comments and complaints from families.

Children, young people, and parents' views are also sought on the quality of their support through audit, and the findings from these are communicated to all staff through the audit newsletter and are explored with the individuals involved in casework through the audit process. In the last audit, children, young people and parents expressed that they wanted social workers to open and honest with them, and that this was really important to them.

Children and young people are aware of their right to complain. Cared for children receive information on how to do this in their 'Coming into Care' Pack and the interactive handbook on the website.

The Improvement Plan Quality Assurance Framework has been based on the quadrant model, which involves gaining the views of children, young people, parents and carers and using this to continually improve services. Children and young people's views are represented at the key partnership boards and drive and inform strategic planning and decision making.

Next steps – how we will sustain and embed progress: In order to develop a culture of putting children and young people first across all of children's services, we are:

- Developing participation training and skills development based on the views, needs and experiences of three teams from each directorate
- Developing a kite mark/ recognition scheme for good quality participation that services can apply for. This will raise the profile of good work in this area, and will be based on the Participation Standards developed by young people.
- Ensuring there is a participation champion from every service who is actively involved in the Participation Network, which will grow the network and ensure practice, skills, training, techniques and standards for participation are disseminated and championed within every department.
- Developing a participation 'toolkit' of resources to support engagement with children and young people for multi-agency workers.
- Putting children and young people first will be a key part of recruitment, selection and induction to ensure we have the right people working with us in Cheshire East who are committed to our values.

Progress against the learning action plan will continue to be tracked and themes will continue to be communicated to staff to continue to improve our service. Feedback from children, young people and parents will continue to be sought and mechanisms to do this promoted in order to enable their views to shape our development.

Ensuring frontline practice is consistently good, effective and outcome focused

2. Ensure the challenge provided by child protection chairs and independent reviewing officers (IRO) addresses drift and improves planning for children

Background to the recommendation:

- In the inspection, a sample of the CP cases open over 15 months showed that there was drift and delay in making progress on plans for some children and young people.
- Child protection review conferences were not always held within timescale, with 11% taking place later than planned.
- Independent Reviewing Officers' (IROs') Practice Alerts were not having sufficient impact on the overall quality of assessment and planning for cared for children.

Activity, current position and impact: Following the inspection, all plans open over 12 months were reviewed to ensure these cases had a robust plan in place. Where there were concerns about drift or delay this was addressed directly.

Performance tracking mechanisms are in now place to prevent delays, such as Safeguarding Performance Challenge Sessions, which scrutinises the cases open over 12 months to ensure there is not drift or delay for these children and young people. The CP IRO Manager is also held to account for progress on all cases open over 12 months in her supervision.

There has been a need to improve working together between the Safeguarding Unit and Children's Social Care and a focus on developing relationships at the frontline.

These services are now aligned under the same Director, and closer working relationships are being supported and developed. Service Managers and IRO Managers are now having regular team meetings and also specific tracking meetings, which is ensuring a shared focus to prevent delays and improve planning, and is improving working relationships.

IRO's are raising issues appropriately through Practice Alerts, but the quality and consistency with which they do this still needs improvement. IROs are required to discuss the Practice Alerts they have raised that month in each supervision to embed good practice and challenge.

More good practice alerts have been made than those that challenge gaps in practice (157) which is positive, and shows that there is evidence of good practice and that this is being recognised.

CP conferences are now being held within timescales, performance was at 92% in quarter 4. This relates to initial conferences as well as CP and review conferences. All review and CP conferences were held within timescales. These initial conferences that were out of timescale were due to delayed notifications. There is some performance information that demonstrates improvement in practice in reducing delay, such as the percentage of children subject to a plan for 15 months or over, where the target is to be under 15% and our current performance is 6%. However, there needs to be evidence of improvement in practice more consistently to show sustained impact. We have launched a new model for CP conferences which should help to support and embed improved practice.

Next steps – how we will sustain and embed progress: The right mechanisms are in place, such as the Practice Alert Tracker, focus on challenge in supervision, and Safeguarding Performance Challenge Sessions. We will continue to focus on embedding good practice around these and developing good working relationships between the IROs and social care teams.

The impact of the IRO's is also dependent on the responsiveness of the operational service and this is still inconsistent. The improvement in planning is linked to the larger requirement to improve the quality of practice across all partners, the action which is being taken to improve both these areas is discussed elsewhere in this report under the relevant sections.

3. Ensure that supervision is reflective, challenging and consistently focuses on continual professional development.

Background to the recommendation:

- Social Workers felt supported by their Managers and received regular supervision, but they could not describe how their practice was monitored or challenged through supervision.
- Managers were not consistently using personal development plans to drive practice improvement through supervision.
- It was difficult for inspectors to see what impact training was making on improvements to practice as explicit links were not made to continual professional development needs.

Activity, current position and impact: Monthly supervision file audits by Service Managers have been introduced and are embedding. The last report for quarter 3 showed that for the Social Workers' supervision files audited, 57% were critically reflective, and 64% evidenced CPD. Performance in these areas needs to significantly improve, but we do now have good scrutiny of the quality of supervision which will support driving up standards in this area. In the social work staff survey in July 2015, 72% said that their manager actively supported them to address their development or training needs, so the proportion of supervisions covering CPD may in fact be higher and the supervision audits may reflect a recording issue. 69% children's services staff had a Personal Development Plan (PDP) in place at the end of the year, which is in line with the wider Council which had a 71% uptake. We will be aiming to improve on this this year.

A core training offer for Social Workers and Managers has been developed and published. This maps expectations against grades of Social Workers and is tied into the grade progression process. Effective supervision training for both supervisors and supervisees is part of the core Social Worker and Manager training offer. The Children's Social Care Practice Standards have been updated and clarify management responsibilities and expectations about supervision. These have been communicated to all staff and compliance with these standards will continue to be measured and evaluated through audit.

The practice coaching audits include reflective discussions with social workers on all the cases that have been audited (around 40 cases), with the option to discuss an additional case chosen by the Social Worker or Team Manager. The additional case could be a particularly complex one or one that would benefit from an independent view/ reflection. This audit model supports Social Workers to develop their reflective skills and their practice overall, and is highly valued by Social Workers.

Next steps – how we will sustain and embed progress: A workshop on PDPs will be delivered in the Practice and Performance Workshops in June 2016 to engage and support staff and managers in the PDP process. Evaluation of compliance and the quality of supervision from the supervision audits in May 2016 will inform further actions. Evaluation of the take up of the core training offer will be evaluated in July 2016, along with its impact on the quality of practice through audit.

4. Ensure that where children do not meet the threshold for social work intervention their circumstances are considered promptly and they receive appropriate and timely early help.

Background to the recommendation: Some contacts that were identified for early help were not progressed as quickly as they could be at the front door as cases for referral to social care were prioritised.

Activity, current position and impact: The Early Help Brokerage Service has been established and went live in October 2015. This service is a dedicated team, with increased capacity, to ensure the swift allocation of early help cases. This ensures timely referrals to early help, and identifies the best service to meet the needs of the child or young person and their family.

There has been a very significant increase in referrals in the North Locality and demand has outweighed our capacity within early help services. Remedial actions are underway to address the significant increase in demand in the north locality. Incoming new service requests are routinely checked (daily) and re-prioritised. All open cases have been reviewed to identify those appropriate for closure/step down to universal services and those cases that can be managed through other services.

The brokerage service has just undergone a business review, to identify opportunities for streamlining this service with Cheshire East's Consultation Service (ChECS) and complex dependencies.

Next steps – how we will sustain and embed progress: Early Help is now supported on the child's record system, and work is underway to build the reporting structures to support effective performance monitoring around referral to and support through early help. Performance information has just become available on the timeliness of decision making in the brokerage service, and a case sample will be undertaken to understand the child's journey, including any delays for cases which are out of timescale and inform necessary action to improve this.

Work around Cheshire East's Parenting Journey will strengthen the early help offer by providing a universal integrated early help pathway and programme of support for children under 5 and their families who live in Cheshire East.

The improvements from the business review to streamline the process for children and families are being implemented. Recommendations for improvement to the referral and allocation systems at the front door will now be implemented through a task and finish group. This group will also scope the full range of early help services across Cheshire East partners with a view to enhancing and improving the range of provision across the continuum of need.

5. Ensure that strategy meetings and decisions are informed by relevant partner agencies.

Background to the recommendation:

- In the majority of cases seen, strategy discussions were telephone conversations between a practice manager and the Police, without the involvement of other agencies, such as health, so decisions did not consistently take account of all relevant information.
- Agencies were not always asked to contribute so not all the relevant information informed decisions.

Activity, current position and impact: Multi-agency Practice Standards have been developed and launched across all agencies in February 2016. These standards set clear expectations in relation to strategy meetings and discussion, i.e., that all agencies and professionals that have a contribution to make to strategy discussions should be invited, and that they should challenge children's social care if they are not included. Work has been completed through the Safeguarding Children Operational Group (SCOG) of partnership frontline managers to raise awareness of

this expectation. Standards for Section 47 enquires and a clear timeline to follow have been issued to support Social Workers.

An IRO themed audit on strategy discussions completed soon after referral was carried out in January 2016. This considered the case notes for 16 families relating to 26 children. The audit found that the recording of the rationale for decision making by managers needs to significantly improve as in 44% cases, based on the referral information, auditors felt that the child or young person had not or was not likely suffer significant harm.

The audit also found that in 75% (12) of the cases, the strategy discussion was held on the same day as the referral, and no significant contact was made with the family or to partner agencies prior to the discussion so referral information was not placed in any wider context. This audit showed that the decision to hold a strategy discussion was often made with too little information, and practitioners were felt to be erring on the side of caution rather than having a clear rationale for why they believed these cases might result in a s47 enquiry, which is an area for further work and development.

The audit also showed that the majority of strategy discussions taking place still only involve social care and the police, with only 1 discussion being truly multi-agency and 1 other including midwifery (13%), so there has not yet been improvement in performance in this area.

Next steps – how we will sustain and embed progress: An action plan has been developed in response to these audit findings. In the exceptional circumstances when a strategy discussion is held only between children's social care and the police, the reason for this is to be clearly recorded on the strategy discussion document held on the child's file. It is expected that this type of strategy discussion would only occur when a child was at imminent risk of significant harm. This will act as a prompt to Team Managers about the need to invite other agencies and will identify themes and issues for further quality assurance activity and the identification of any obstacles that need to be challenged in achieving multi-agency strategy discussions.

The Police Public Protection Unit (PPU) will gate keep requests for a strategy discussion and will challenge children's social care when they feel that the request is made without sufficient information, or when other agency information is not available, or that the team manager/Emergency Duty Team worker is erring on the side of caution without sufficient evidence to suggest risk of significant harm. The PPU will record this gatekeeping activity to allow themes and issues to be identified and for consistent thresholds to be introduced.

An audit of strategy discussions will be repeated in September 2016 to evaluate the impact of this further work and the awareness raising and Multi-agency Practice Standards.

6. Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded.

Background to the recommendation:

- Not all CAF assessments recorded children and young people's views.
- The rationale for closing CAF plans was not always clearly recorded, making it difficult to evaluate the effectiveness of the help received.
- Historical information considered in decision making on contacts was not always recorded in as much detail as it needed to be, which led to delays as Practice Managers needed to request further information to make a decision.
- There was not always a clear rationale recorded on contacts for why the decision had been made to proceed without consent for information-sharing.
- Practice Managers' oversight of casework was not clear in most of the cases seen, and there was little evidence of direction, challenge or support where plans for children had not progressed or work had not been completed in a timely way.
- Key discussions and decisions were not always fully recorded on the child or young person's record. This made it difficult to follow the child's story, to evaluate if further work could have prevented the child or young person becoming cared for, and could mean important information could be missed by new workers to the case.
- The work presented to courts was of variable quality.
- Recording was not always detailed enough to show the benefits of contact with families for cared for children and young people.
- Information recorded on return home interviews was not always comprehensive.

Activity, current position and impact: A core training offer for Social Workers and Managers has been developed to embed expectations around the quality of practice and ensure that the whole workforce has the skills they need to deliver this level of service.

Performance Challenge Sessions now take place on two levels; Senior Managers challenge Service Managers on their service's performance, and the sessions have also been extended to Team Managers and Social Worker Pod Teams, which are challenged by the Service Manager. IRO Managers also have Performance Challenge Sessions for their IRO Teams. This process is embedding well. These sessions focus on quality of practice, down to individual performance level, including caseloads, timeliness of assessment and plans, supervision and management oversight, and are successfully continuing to drive improvements to practice and embed accountability.

Research has been undertaken on good practice models in other authorities and options to develop one way of working/ operating model across all social work teams in Cheshire East are being explored. Project work, to inform the operating model for Children's Social Care, is about to commence.

Sharing and celebrating good practice is now established at Practice and Performance Workshops and Practice Champions meetings. Social Workers and Team Managers present examples of their own good practice to increase recognition and understanding of the features of good practice.

The quality of recording continues to be evaluated through audit and the practice coaching audits continue to support workers to reflect on the quality of their work and where they can improve and develop. 76% (57) files audited in quarter 3 met the practice standard for recording management decisions, which shows this is an area that still requires improvement.

Overall, all of the audit streams showed that the majority of practice is judged to require improvement, with some inadequate cases (although these are reducing) and some good cases. Requires improvement is a broad category in terms of the quality of work it covers, and it is positive that inadequate practice is reducing, however we are aiming that all casework is good or outstanding. This will take time to establish and embed.

Despite the quality of practice not yet being at the level of quality we want it to be, children and young people are safe in Cheshire East, and the last Practice Manager audit supports this which showed that in all cases (of 9 cases) social workers were judged to have taken the right action at the right time to protect children and young people, and in 89% (8) cases there was evidence that the work had improved outcomes for the child.

The themes for improvement that have been identified through audit are:

- Assessments need to be updated to reflect changing circumstances
- Plans need to be SMART and tailored to each child's individual needs
- Recording needs to be clear and fully reflect the work undertaken, this includes recording the rational for management decisions
- Chronologies and family history need to be used to inform decision making and planning.

Next steps – how we will sustain and embed progress: We will evaluate attendance on and impact of the core training programme. The focus on standards expected and individual accountability will continue through the Performance Challenge Sessions. Practice coaching audits will continue to focus on supporting the quality of recording and case work. This, and evaluation of the impact of core training offer will inform the next steps. Whilst not a quick fix, the development of a Cheshire East model for social work does has the potential to have a significant impact on the quality of recording and decision making.

A review of the processes for centrally monitoring and tracking CAFs will take place. In addition, a performance management framework will be refreshed and a quality assurance framework developed for all early help cases.

7. Strengthen frontline practice to ensure effective action is taken to support children at risk of child sexual exploitation and those who go missing.

Background to the recommendation:

- The findings from return home interviews were not always being used to inform on-going work with children and young people, or to explore wider issues such as links with other missing young people.

- The response to children going missing from care was variable, the recording of return home interviews was not always comprehensive, and there were delays in these being sent to Social Workers.
- Tools to assess the risk of child sexual exploitation were being used, however there was not enough skilled, sensitive work completed with children and young people to understand their individual vulnerability and risk.
- Some Social Workers had not had training in recognising and responding to the signs of child sexual exploitation due to the high turnover of staff.

Activity, current position and impact: A Missing from Home Team was established in 2012. This was extended to include CSE in April 2014. Other agencies; police and health, have become part of this team during this period. This service supports workers on an individual case by case basis through consultation, guidance, resources and case direction/ supervision. This specialist service should improve the quality and coordination of CSE and missing from home and care (MFH&C) work. An active CSE Champions Group is in place and this is driving improvements to practice through feedback from frontline practitioners and children and young people.

The relationship between the CSE and Missing from Home and Care Service and the new Early Help Brokerage service has continued to grow. Sharing of information has been extremely beneficial in making decisions on what service will best meet the needs of children and families. The service has also been able to draw on the expertise and provide consultations and resources for those children who are already involved with some of Catch22's other services in Cheshire East, including the Family Focus (Troubled Families) workers, Project Crewe Child in Need Team and the services for those not in education, employment and training (NEET) and Drug services. The service has worked closely with the workers involved with these services to ensure appropriate planning and support around Missing from Home is included in their ongoing plans for children and families.

The Integrated Team were joined by a MFH/CSE Nurse Specialist during this quarter and this has provided wider consideration for young people who are high risk Missing From Home individuals, and has widened the amount of immediate information and joint working within the local authority. It is hoped that going forward, health services will become more involved in planning for these children.

The Missing From Home Case Workers continue to be part of the CHAPS (Care Homes and Police) Operational Group and these meetings have been key in establishing links between young people from different care homes and sharing information between police and care homes. Importantly, all children and young people supported through this service reported that they felt safer following this support.

A multi-agency audit of the quality of the use of the CSE screening tool in February 2016 by the CSE Champions Group found that 63% (10) were good, 25% (4) required improvement, and 13% (2) were inadequate. However, this audit also showed that the quality of work recording the views of children and young people was variable, and this was an area that was identified for improvement.

The forums through which practice with children who are at risk of CSE are monitored, and the recent multi-agency CSE audit, shows that children are not yet

always being identified early enough and the quality of assessment planning and intervention can still be improved.

Tools and training to support social workers with direct work have been developed and delivered through Practice and Performance workshops. A range of training around CSE has been provided, and CSE and Missing from Home and Care is a mandatory training course for all Social Workers. A session on CSE and MFH&C was also given at the Practice and Performance workshops in December 2015 to social workers and managers. The CSE/MFH team have offered a number of sessions to provide every social worker with the opportunity to have basic CSE training. The new core training offer was launched in March 2016 and take-up and impact of training will be closely monitored this year. A considerable number of social work staff are now registered to attend this training. An e-learning module on CSE is also available.

71% return home interviews were completed following an incident of missing from home or care this quarter. Return home interviews are sent to social workers and the timescales for this are performance managed. Social workers also get a follow-up call to ensure they are aware of the issues, and where there are high level concerns, these children are discussed first and the recording is prioritised. There has been an improvement in return home interviews being placed on the child's file by social workers, but this still needs further improvement.

There is inconsistency in the use of return home interviews to inform the understanding, assessment and plan for the child. This is linked to the wider need to improve the quality of practice. To assist and support improvement in this, the return home template has been changed so that it clearly identifies the immediate risks to children and young people in a separate section which social workers can use to inform assessment and planning.

Next steps – how we will sustain and embed progress: The Missing from Home and CSE Team will be visiting social work teams to identify specific issues that workers have and how best to support best practice. This will also form a key element of the business plan for this service.

Work is underway to develop best practice standards for CSE conferences, including good practice examples of the use of screening tools, reports, meetings and interventions. This will ensure that it is clear what a good standard of service looks like and will make expectations clear for practitioners.

The multi-agency audit of CSE work will be repeated in 6 months to evaluate impact on practice. Evaluation of the uptake and impact of the core training offer will be completed in 6 months time.

8. Ensure assessments for children in need of help and protection and children looked after are timely, consistently consider the full range of children's needs, contain thorough analysis and are routinely updated to reflect changes in circumstances.

Background to the recommendation:

- Not all assessments were of a sufficient quality

- Not all assessments demonstrated that the risks to children and young people from domestic abuse, parental mental health problems or substance misuse were fully considered and understood and Adult Social Care was not routinely involved in assessments where factors for adults were present.
- The specific needs of each child or young person within the family were not always differentiated.
- Issues of diversity and cultural needs were not consistently well explored or responded to. Assessments did not fully explore issues of race and gender and how they impact on children and young people's experiences within their own family.
- Assessments were not consistently updated in response to a change in circumstances.
- When children and young people returned home from care an updated assessment was not always undertaken to inform this decision and identify the appropriate level of support needed.
- In some cases, contact with families for cared for children and young people was not always rigorously risk assessed.
- Where cared for children were living with friends or relatives, assessment of those connected persons was not always sufficiently robust.
- Timescales for completion of assessments were not always adhered to.

Activity, current position and impact: As detailed above work is underway to develop a single operating model for Children's Social Care in Cheshire East. The assessment framework and practice standards have been reissued to ensure the standards for assessment are clear to all staff. This includes what constitutes a good assessment. A range of activity is taking place to support the development of good quality practice, as detailed under section 6. Improvements to the quality of supervision will also impact on practice, and this is detailed under section 3.

However, currently, the majority of practice still requires improvement, and ensuring assessments are routinely updated and consider the full range of children's needs remains an area we need to improve which has been shown through the audit findings from quarter 3.

Next steps – how we will sustain and embed progress: We will continue with our focus on the supporting the quality of assessments through audit, and will continue to drive improvements to timeliness through the Performance Challenge Sessions.

Exemplars for social workers will be produced through the Practice Champions Group to demonstrate what a good assessment and plan looks like and how children's views and lived experience should be captured.

Recent audit and performance has revealed the need to review the workflow for combined assessments, care plans and pathway plans, to make the process and requirements clearer for social workers. The workflow will be reviewed to ensure that this supports effective practice and is easy and intuitive to use.

9. Ensure that plans to help children in need of help and protection, looked after children, and care leavers, are specific, clear, outcome-focused and include timescales and contingencies so that families and professionals understand what

needs to happen to improve circumstances for children. This includes improving the clarity of letters before proceedings so that the expectations of parents are clear.

Background to the recommendation:

- Child Protection Plans and Child in Need Plans were not always specific to individual children, and not always of a good enough quality.
- Plans lacked timescales and contingencies.
- Plans were not consistently underpinned by a full understanding of whether changes were sustainable.
- Direct work with children and young people was not always informed by the assessment or the plan so lacked focus.
- Some Social Workers were too slow to respond to the lack of progress against plans for children and young people; some Child Protection Plans showed delays and drift and some children experienced delays with their permanence plans. Some cases took too long to step up to Child Protection.
- Not all partners were as involved in planning as they could be. Adult service Social Workers and Housing Providers were less involved, and this meant that there was not always a coordinated multi-agency response.
- The quality of Personal Education Plans (PEPs) has improved, but some were not detailed enough and did not contain precise enough targets.
- The majority of pathway plans did not have clear and specific targets and actions to help or encourage young people to secure employment, education or training.

Activity, current position and impact: A new model for Child Protection Conferences has been introduced which focuses on ways to include the family in planning, and focuses on the strengths of the family as well as the areas that need to improve, which helps to engage children, young people and families in the planning process. It also helps families to understand why the plan is in place and what needs to happen to achieve it. Improved understanding and engagement with the plan and agencies delivering it should lead to improved outcomes for children, young people and families. We are in the process of carrying out a mid-point review of the model. Anecdotally, it appears that the model has been well received as an improvement in addressing the issue of drift and improving planning.

The core training offer for Social Workers and Managers will support workers to develop the skills to produce and support strong assessments and plans. Training on delivering direct work with children and young people has been delivered to ensure that this is of a good quality and is informed by assessment, analysis and planning. The impact of this will be reviewed in 6 months time.

The Practice Champions Group have designed and developed tools to support direct work, and these were produced into a 'tool kit' which was given to all social workers, and there is an area in each of the social work offices which features these tools. Training on direct work has also been delivered through the Practice and Performance Workshops.

A new quality assurance process for Personal Education Plans has been developed, which includes local Head teachers providing external scrutiny on the quality and challenge to schools. This will help to embed standards and drive up the quality of practice. Best Practice examples of PEPs are on the Cheshire East Virtual School

website, and this has been communicated to schools. These best practice examples are shown to new Designated Teachers as examples of effective PEPs as part of their induction.

A new post of designated Service Manager for Care Leavers has been created and appointed to, which will provide additional capacity, management oversight and focus on improving outcomes for Care Leavers. This specialist care leavers' service allows specialist support, expertise and focus on the particular needs of these young people as a group.

Performance on the timeliness of plans has improved, the last audit found 67% CIN plans were completed within 35 days, but this is still an area requiring further improvement. As discussed in previous sections, the quality of practice requires improvement and planning is still a key area that we need to improve.

The number of children and young people subject to a plan for emotional abuse has risen. A recent dip sample in January 2016 of child protection plans for the category of emotional abuse showed that this category is sometimes incorrectly used, and that deeper analysis needs to made and evidenced in conference discussions to ensure that the reason the plan is needed and the impact on the child or young person is correctly identified. Without this it is difficult for parents to understand why professionals are concerned and what they need to do to reduce these concerns.

This audit highlighted that we need to ensure planning is more solution based and family focused; plans need to cover how parents will be supported differently to achieve the aims in the plan that they were unable to achieve at CAF or CIN level. This will be address through the new conference model, but at this point in time it is too early to evaluate the model's impact.

Next steps – how we will sustain and embed progress: Work is underway to develop a multi-agency framework to support professionals working with substance misusing parents. We will continue with our focus on the supporting the quality of plans through audit, and will continue to drive improvements to timeliness through the Performance Challenge Sessions. A mid review of the child protection conference model will be carried out in June 2016.

A model for IRO's systematically auditing child in need cases has been introduced in April 2016. The first quarter will focus on auditing all plans over 12 months. The model also encompasses some observation of CIN meetings. The model will focus on auditing a sample of CIN cases open over 6 months to assess the quality of this work. A repeat audit of new plans under the category of emotional abuse will be undertaken in August 2016 to evaluate improvements in practice in this area.

10. Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded.

Background to the recommendation: Inspectors saw a number of cases that had been closed to children's social care and stepped down too soon, where not

enough progress had been made, and change had not been sustained to secure improved outcomes.

Activity, current position and impact: The policy on Step Up and Step Down has been reviewed, updated and relaunched. Managers chair Step Down meetings so that they have oversight of the case and ensure the arrangements around step down are robust. Training on Chairing Meetings effectively is part of the core mandatory training programme for managers to ensure they have the skills to chair more complex meetings. All actions to address the recommendations from the LSCB multi-agency audit on Step Down have been completed.

In the last audit, only one case audited was stepped down. However this case showed that there are still issues with robust arrangements for stepping down, as this case was closed from CIN and the decision was made that support at CAF level was not needed. The auditors queried this decision and it was accepted that support should be given at CAF to ensure continued support was offered. However, the auditors did agree that this was the right time to close the case at CIN.

Next steps – how we will sustain and embed progress: We will continue to monitor progress through audit that the decision to step down or close cases is appropriate and the management rationale for this is clearly recorded. Step down of cases is proposed to be a thematic area for the LSCB to revisit in its audit programme in 2016-17 which will give an in-depth picture of progress in this area.

11. Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays.

Background to the recommendation: All foster carers spoken to in the inspection were aware of the delegated decision making process, but they felt that Social Workers still have to complete too many forms for decisions foster carers could make.

Activity, current position and impact: The Foster Carers' Handbook has been reviewed and revised along with the policy on delegated authority to ensure the guidance is clear and consistent for Social Workers and Foster Carers. A simple checklist has been produced on delegated authority, setting out what areas carers can make decisions on, which Social Workers make decisions on, and which need to be agreed and specified in the plan; this is included within the Foster Carers' Handbook. Awareness raising of delegated authority has been carried out at the Practice and Performance Workshops, Foster Carers' Forum and through the Foster Carers' newsletter.

Next steps – how we will sustain and embed progress: Work is necessary to improve the forms on the child's record system to support improved practice. This involves a potential new Care Plan document which puts delegated authority in a clearer format. Work is underway reviewing this. The Foster Carer's survey will be carried out this year and will assess whether carers are clear on delegated decisions.

12. Improve the timeliness of initial health assessments so that children who become looked after have their own health needs assessed within the expected timescales.

Background to the recommendation:

- Most cared for children had an assessment of their health needs, but there were delays in some initial health assessments taking place.
- Only 30% of initial health assessments for cared for children and young people in were completed within timescale in 2014-15 due to delays in Social Workers requesting assessments.
- Review health assessments were timely.

Activity, current position and impact: The process for requesting initial health assessments has been streamlined and a new pathway has been developed and is in place. The process is now prompted in the child's record system to support timely requests and completion. The impact of these changes have not yet been realised in the performance measure and this area continues to be under scrutiny by the Corporate Parenting Board and the LSCB, both having received detailed reports around the issues. A case example was also presented to the Corporate Parenting Board in March 2016 for detailed analysis. The Health and Wellbeing Board has also received a report on the health of cared for children, which highlighted this issue.

For performance to improve, it is critical that there is an early and timely request for the initial health assessment from the social worker, as the assessment needs to be completed within 20 working days to be within timescale.

During quarter 4, 20% requests for initial health assessments were received within 48 hours of the child or young person coming into care, which needs significant improvement. As a result, there has not yet been an improvement in the number of initial health assessments that were completed within 20 days.

All Social Workers and Team Managers have been reminded of the pathway and procedure for requesting these, and the expectation that requests for these assessments are made within 2 working days of the child or young person coming into care. A new process has been put into place to ensure timely referrals are made and this becomes embedded. The placements service are notifying the Head of Service when a child or young person comes into care, and the Head of Service will track compliance with the standard and will report any exception to the Director of Children's Social Care. The Cared for Nurses have attended the Practice and Performance workshops to raise awareness of the health assessment pathway, and the Designated Doctor will raise this issue again with the relevant paediatricians.

A Health app for cared for children and young people has been developed and launched to support them to get advice about health issues and where to go and what to do to meet their health needs.

Next steps – how we will sustain and embed progress: Performance to remain under scrutiny by the Head of Service and key partnership Boards until improvement in performance is sustained. The Director of Children's Social Care will challenge requests out of timescale to embed timeliness.

Work is underway to look at the current processes to see if health professionals can be involved earlier in the process to provide up to date and relevant health information to inform assessments and plans.

17. Ensure later-in-life letters provide details of all known information, are written in plain English, and are accessible to children so that they understand their stories.

Background to the recommendation: Later in life letters were variable in quality.

Activity, current position and impact: The production of later-in-life letters has been allocated to the Adoption Team, to ensure consistency of approach. All later-in-life letters are quality assured by Team Managers, and this is overseen by the Service Manager for Adoption. This has established a good quality standard and letters are being produced to a good standard. Consultation with care leavers has taken place on what constitutes a good later-in-life letter and this has informed the production of good practice exemplars.

Next steps – how we will sustain and embed progress: Team Managers will continue to monitor the quality of the letters, and there is a tracker in place to ensure the timeliness of these.

Improving senior management oversight of the impact of services on children and young people

1. Strengthen senior managers' oversight and monitoring of:

- ***complex cases where there are historic drift and delay in taking decisive action***
- ***private fostering and connected persons' arrangements to ensure that these arrangements are suitable and comply with regulations***
- ***care leavers who are homeless***

Background to the recommendation:

High Risk cases:

- In the inspection, inspectors saw two cases where drift and delay (across CIN/CP and cared for) had impacted on the child or young person's safety and progress, but this had not been alerted to senior managers. Inspectors suggested one of example of how this might be addressed through a high risk panel.

Private Fostering and Connected Persons Arrangements:

- Service Manager's oversight of private fostering and connected person arrangements needed to be strengthened. Private Fostering cases sampled during the inspection showed delays in responding to notifications, disclosure and barring (DBS) checks, visits and decision-making. There was no evidence of management oversight identifying or challenging these delays.
- Where cared for children or young people live with relatives or friends, assessments of connected persons were not always sufficiently robust, timescales for completion were not always adhered to, and it was not clear in all cases if assessments had been signed off by Group Managers.

Care Leavers who are Homeless:

- Group Manager's oversight of care leavers who are homeless needed to be strengthened. At the time of the inspection 6 care leavers were refusing appropriate accommodation, all of them had multiple problems, including drug and alcohol misuse, risk of or actual offending behaviour, and emotional health problems. Personal Advisors were making concerted efforts to engage them with services and reduce the risks, however outcomes for these care leavers were uncertain due to the complexity of the needs. Senior managers did not have sufficient oversight of these care leavers who are homeless, and did not routinely monitor the individual circumstances for these highly vulnerable young people.

Activity, current position and impact: The multi-agency professional dispute resolution (escalation) process has been reviewed, revised and relaunched to ensure it is explicit about the criteria for raising concerns where drift or delay are impacting on the child's safety or progress. The resolution workflow has been incorporated into the child's record system to ensure that the process is systematic and the pace of resolution can be tracked and monitored. This is currently in the final stage of testing. Drift and delays are being challenged by IROs through the Practice Alert process. Criteria for a protocol on notifying all tiers of management on high risks cases is being developed.

A tracking system for all privately fostered cases has been established and is managed by the lead IRO. The Placement Service seeks confirmation at the time of referral about the exact arrangements for the child's placement, and where relevant, the allocated IRO ensures that issues pertinent to connected person's assessment, particularly any identified risks, as well as the support package, are scrutinised during the preparation for the first (20 days) review. 93% (14 of 15) private fostering visits were completed within timescale in quarter 4, and the one which was outside of timescales could not have been foreseen, so this is very good performance and is a considerable improvement on performance during the inspection in quarter 2 which was 67%.

This year we have nearly doubled the number of privately fostered children and young people we are aware of in Cheshire East, from 6 to 11 new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases. All the reg. 24 assessments were presented to the fostering panel within statutory timescales in quarter 4.

A monthly permanence case tracking meeting, chaired by the Head of Service for Cared for Children, has been introduced to ensure clear senior management oversight and drive for permanence. The tracker for care leavers who are homeless

has been strengthened and is being used to effectively track and monitor these young people, and this is overseen by the Service Manager.

Next steps – how we will sustain and embed progress: A protocol that sets out when and how all tiers of management up to the Director of Children's Services will be informed about a case based on the risks to the child or young person will be developed. Mechanisms to track these young people and ensure senior management oversight are now in place and we will continue to evaluate the impact of these measures on outcomes for children and young people. A multi-agency stocktake of private fostering cases will be carried out in June 2016.

13. Ensure audit arrangements have a sharper focus on looked after children.

Background to the recommendation: Some of the audit programme was focused around the performance and quality of services for child in need and child protection, as these services had been inadequate. Plans were in place to extend the current audit programme to cared for children but this had not taken place at the time of the inspection.

Activity, current position and impact: The audit programme for children in need and child protection has been extended to cover cared for children's services, so this now reviews the quality of casework across the whole service; from contact at the front door to leaving care. Audits are completed and reported on a quarterly basis, and cover 57 cases.

The main themes from audit are given under section 6.

The impact that the findings are having on practice is not yet evident across all areas for our cared for children, but there are indications that some areas show improvement e.g. recording of management decisions being recorded on the child's record, and statutory visits in timescales. However, practice for cared for children generally requires improvement.

Next steps – how we will sustain and embed progress: The audits will continue to reflect and report on the compliance and quality of practice for Cared for Children in Cheshire East, to supplement other performance information to managers. The improvement in practice will be reflected as other areas for action make progress.

14. Ensure that comprehensive and clear data and performance information are provided to managers and strategic leaders to enable them to better understand, oversee and scrutinise performance. This includes ensuring the accuracy of the information provided through the electronic recording system so that managers have effective oversight of frontline practice.

Background to the recommendation:

- There was no annual performance report for children's services to outline and explain our progress compared with previous years against national performance and statistical neighbours, which would assist political leaders, partners and staff

to understand and follow the improvement journey and demonstrate what performance means for children and young people.
- The electronic recording system for Children's Social Care was replaced with a modern case management system to support effective social work practice.
- The migration of data from the old system to the new one resulted in some anomalies and unreliable data. As a result, managers were not always confident about what the data was telling them, and managers were unable to readily identify the right data without a time consuming check of individual records or audits of casefiles. This made it difficult for managers to understand and manage performance in their services and teams.

Activity, current position and impact: A performance scorecard for the whole of children's services has been developed, the annual version of this will be received by Children and Families Scrutiny Committee to support them to determine the areas of focus for the year.

Work has been completed to develop performance monitoring across teams and to ensure a range of reporting suites are available on children in need and child protection, cared for children and care leavers. As at the end of March 2016, there are 61 live reports in the live reporting environment that can be run by Managers and staff to complement the reports that are readily available from the live electronic recording system. Live performance profiles are also available for each team manager to run which shows their team's performance against the key areas, such as timeliness.

An additional 5 reports are currently in development. The key areas for development are adoption and fostering reporting suites, and the implementation of the Early Help module and the supporting reporting infrastructure.

Training has been provided to all managers around running and extracting reports to support performance management. In addition, requests are received by the Business Intelligence teams to provide reports to support performance monitoring. Use of these by managers is still not routine but this is improving substantially.

Performance Challenge data is produced and sent to managers on a fortnightly basis to supplement readily available reports. Performance Challenge Sessions now take place on two levels; Senior Managers challenge Service Managers on their service's performance, and the sessions have also been extended to Team Managers and Social Worker Pod Teams, which are challenged by the Service Manager. All performance, including individual performance is scrutinised through the performance challenge sessions, which is helping to embed accountability and the expectations on practice. These sessions are also supporting development of a culture of performance monitoring and challenge from team managers.

The Performance Challenge sessions have substantially improved the timeliness and accuracy of data loaded into the system. Any areas of concern are highlighted at challenge sessions or with specific managers.

Specific performance areas are also explored through various monthly tracking meetings, such as cared leavers in unsuitable accommodation, and a range of trackers are kept to facilitate detailed scrutiny on performance in these areas.

It has been 18 months since the launch of the new child's record system, and the quality of data due to migration is no longer a significant issue as it was at the time of the inspection. The quality of the data is becoming better and better as time progresses and new records are loaded onto the system. Monthly case management development sessions are held with LiquidLogic to support developments to the system.

Next steps – how we will sustain and embed progress: We will continue to develop the suite of live reports available and support good frontline practice and recording to ensure the quality and integrity of the data. The Business Intelligence Team has a list of reports requested and those currently in development, and these are discussed at the monthly case management systems meeting in terms of priority for development. Performance will continue to be closely monitored to drive improvements through the Performance Challenge Sessions.

16. Strengthen commissioning arrangements to ensure that services meet the needs of families and children in need of help and protection and children looked after by:

- ***Reviewing the use of foyer accommodation for 16-17 year olds***
- ***Ensuring that rigorous risk assessments are undertaken before the placement of young people in foyer or hostel accommodation, and review the practice of using this provision***
- ***Ensuring sufficient health provision for older looked after children and care leavers***
- ***Improving the use of family group conferences so that all possible options for children are consistently explored***
- ***Increasing the capacity of advocacy services to support children and young people identified as in need.***

Background to the recommendation:

- There was no joint commissioning strategy in place.
- Foyer accommodation was used as a last resort for young people who are not yet adults. Providers of this accommodation completed risk assessments on all young people under the age of 18 at the start of the placement, but did not routinely complete them on older care leavers who could be equally vulnerable.
- Assessments for these young people were not detailed enough, and did not specifically address the potential impact of the setting on the young person.
- The 16+ Cared for Young People's Nurse post had been vacant since April 2015, and although this post was covered, it was not always provided by the same person which reduced consistency.
- There was no specialist health resource for care leavers over the age of 18.
- Family Group Conferencing was not used well and its impact was not known.
- Not all children in need were offered advocacy.
- Some cared for children experienced delays in being matched with an independent visitor.

Activity, current position and impact: A Children's Joint Commissioning Strategy has been drafted. This was discussed at Children's Senior Leadership Team in February 2016 and will be considered by the Health and Wellbeing Board in May.

Cheshire East is adopting the ignition approach, which is based on the voice of individual young people directly influencing decisions about their 16+ accommodation and support. The approach assesses the full range of accommodation offer (including Foyer) to ensure the most appropriate placement decisions. A robust risk assessment tool is now in place for use with YMCA/ foyer accommodation.

The 16+ and transition nurse post has been advertised to cover Cheshire East's 16-25 year old young people. Interviews are planned for April 2016. A Nurse Specialist for Cared for Children has taken up this post working 2 days alongside the Designated Nurse for Cared for Children. The CCGs are reviewing the provision of cared for children's health services to ensure that this is effective across all service areas.

The use of Family Group conferencing has been reviewed. Family Group Conferencing will be brought in house and will be integrated as part of the new model for children's social care to improve consistency and support for families.

The take up of advocacy and independent visiting services has been reviewed and target priorities have been set through negotiation with commissioned provider, The Children's Society. The contract has been amended to ensure the advocacy service is offered to children and young people on a CSE plan, and all children subject to a plan prior to their first review.

71 children and young people were accessing advocacy in quarter 4. 94% young people were pleased with the service they received. The Independent Visiting Coordinator and the Service Coordinator have promoted the service to social workers at the Practice and Performance workshops in June 2015. New leaflets have been produced to promote the service, which social workers share with children and young people. Young people have developed a short animation for young people to explain the role of an advocate and an independent visitor which will also be used to promote the service to children and young people.

Next steps – how we will sustain and embed progress: We will continue to work with Crewe YMCA to improve the foyer offer. We will continue to track and monitor all care leavers deemed to be in unsuitable accommodation to actively seek alternatives that meet their needs. We will inform the review of the provision for cared for children's health services. We will continue to monitor the up take and quality of advocacy and independent visiting. We will develop one model of working within children's social care which includes Family Group Conferencing.

Ensuring the partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East

151: Complete work to develop the performance management framework so that service effectiveness can be evaluated rigorously across all agencies

Background to the recommendation: Use of performance data to analyse and scrutinise partnership performance was not fully developed. More work was needed in order to reach an agreement on which data should be included within the LSCB

performance scorecard in order to ensure robust oversight and scrutiny of safeguarding practice.

Activity, current position and impact: The LSCB scorecard has been further developed and strengthened; it covers a range of measures from all partners and has been aligned with the areas of focus for the LSCB and the partnership from the Ofsted Inspection Report. It now gives a robust oversight of safeguarding practice across the partnership. The LSCB Quality and Outcomes Sub Group is effectively scrutinising and challenging partnership performance, and is driving improvements to partnership working. This includes identifying risks to improving outcomes across the partnership that are subsequently added to the LSCB's risk register where they are monitored and challenged until progress is made.

A range of quality assurance activity supports performance monitoring. Arrangements for this are robust, and support and supplement partnership performance monitoring. This includes the LSCB multi-agency audit programme, LSCB frontline visits, and the annual LSCB Children and Young People's Challenge and Evidence Panel. The Challenge and Evidence Panel is run by young people, who challenge LSCB members on the key safeguarding issues that are important to children and young people in Cheshire East. This is informed by the themes highlighted in the Children and Young People's Safeguarding Survey.

LSCB audits have shown that further work is needed to improve SMART planning, and ensuring that the progress against plans is evaluated and tracked in meetings. In the last LSCB thematic audit on parental mental health, 60% plans were considered to be clear, but all other indicators of a SMART plan were considerably lower with 54% considered to be outcome focussed, 58% focussed on risk and need, 56% clear about professional roles, and with contingency arrangements outlined in just 37%. In response to this, all LSCB multi-agency training now includes references to SMART planning, and the Safeguarding Children Operational Group (SCOG) are reviewing and updating the one minute guide on SMART planning so this can be communicated widely across the partnership to support good practice. Improvements to SMART planning and the quality of plans are also being driven through Children's Social Care which is discussed in detail in section 9.

Findings from LSCB audits are driving improvements to practice. The need to improve communication between GPs and the safeguarding unit so that GPs are aware of the concerns and inform child protection planning was a recurring theme from the last two LSCB audits. The named GP has visited the visited the majority of GP practices in Cheshire East completing direct work with the practice managers to improve their processes and arrangements. Work has been completed between the safeguarding unit and the named GP which has resulted in strengthened data reporting. Quarterly reporting has now been established to monitor the impact of the work to improve communications. As a result of this work, the percentage of initial case conferences informed by GP reports has improved from 35% in quarter 2 to 62% in quarter 3. This still needs to improve and further work is being carried out to ensure progress in this area continues to be made. Quarterly updates are received and scrutinised by the LSCB Quality and Outcomes Group to drive and monitor the progress in this area. Work is underway within Children's Social Care to ensure GPs are notified of children in need (CIN).

LSCB frontline visits have shown that there is commitment to engage children and young people in service planning across the partnership, and some good examples of this were found such as children and young people's participation in developing the new child protection conference model. Frontline staff welcomed the feedback from LSCB audits through the staff newsletter and said they used this to improve their practice. Most organisations provided examples of how they have learned from SCRs and this was cascaded well throughout the teams via team meetings and bulletins. Most staff felt confident in raising a challenge and some have experienced their service challenging another agency or partner agency challenging them. However, staff were unclear on the policy and procedure for resolving professional disagreements. This policy and procedure has now been reviewed and strengthened, and the resolution process has been incorporated within the child's record system. Awareness raising of the new policy and procedure has been completed with frontline managers through the Safeguarding Children Operational Group (SCOG) and through the Multi-agency Practice Standards.

Next steps – how we will sustain and embed progress: The LSCB quality assurance framework will be revised in April/ May 2016 in line with the production of the LSCB annual report and the review of the LSCB Business Plan priorities. The LSCB multi-agency audit process will be reviewed as part of this process to align with the business plan priorities and key areas for partnership improvement in the Ofsted inspection report. A multi-agency audit on the toxic trio will take place in May 2016 to complete the current LSCB audit cycle. The findings from this will be used to drive improvements and to evaluate progress.

The LSCB frontline visits and LSCB Challenge Sessions are both effective, established methods of scrutinising partnership practice. These two methods will be dovetailed to allow evidence from service managers and the frontline to be triangulated with performance information around the LSCB's key priority areas.

IROs will attend the GP level 3 safeguarding training In April 2016 to cover what makes a high quality conference report and to remind GPs of the process for case conference. The named GP is currently undertaking targeted practice visits to those practices that appear to not be submitting reports consistently to ensure they have robust processes in place. Reports on progress in this area will continue to be received by the LSCB Quality and Outcomes Sub Group.

152: Provide regular scrutiny of services for looked after children. Monitor and review the application by partner agencies of the threshold framework and take appropriate action where necessary.

Background to the recommendation:

- The focus of the LSCB's work and scrutiny had been on child in need and child protection services, as these had been inadequate.
- Cared for children's services had not received the same level of scrutiny and challenge on the quality of their service provision.
- Consideration and scrutiny of early help services was not sufficiently embedded in the strategic oversight and work of the LSCB.
- There were inconsistencies in stepping down to lower levels of intervention.
- Escalation processes were underused.

Activity, current position and impact: The business support functions for the LSCB and the Corporate Parenting Board have been aligned within the same team which is ensuring that both boards are sighted on the key issues and are informed of the activity of one another. Key reports on the quality of cared for children's services have already been received by the LSCB, Executive and relevant subgroups and further reports are scheduled for receipt by the LSCB over the year. The LSCB also receives regular updates on progress against the Improvement Plan, including areas relating to cared for children.

An Early Help Challenge session was carried out in November 2015 where the LSCB scrutinised and challenged the quality of early help provision across the partnership. This session found that early help services need to be more joined up, including with adult services, and that monitoring and evaluation of the quality of work needs to be strengthened. Since this session, a LSCB Early Help Sub Group has been established to drive improvements to the quality of early help services, and this sub group reports to the LSCB Executive.

Reports on the application of the threshold framework are received and reviewed by the LSCB to ensure this is applied consistently across the partnership and this is considered through the LSCB audits and LSCB frontline visits. The LSCB frontline visits completed in quarter 3 found that most practitioners had a clear understanding of thresholds and that this is supported through training and advice available.

The professional dispute process has been revised and relaunched to make it clearer in response to staff feedback received through the LSCB audit and frontline visits as outlined above.

Next steps – how we will sustain and embed progress: Reports on the quality of cared for children's services and the Improvement Plan will continue to be received regularly by the LSCB.

Evaluation of the application of thresholds will be included within the revised LSCB multi-agency audit process. The application of thresholds will be a key focus at the LSCB's Leadership Summit in May.

The Early Help Sub Group will continue to drive and coordinate improvements to early help services across the partnership and this will be monitored by the LSCB and LSCB Executive to ensure that the recommendations from the Early Help Challenge are met. The CAF audit process is currently being reviewed and revised to strengthen this as a form of evaluation, and these audits will be reported to the Sub Group.

The application and use of the professional disagreement and resolution policy will be evaluated and reviewed to ensure it is resulting in the desired impact.

153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.

Background to the recommendation:

- In response to high numbers of children and young people subject to child protection plans due to neglect, the LSCB launched a neglect strategy in January 2015.
- The graded care profile was not being used consistently to assess neglect cases.
- Plans were in place to undertake further work to embed use of the tools, and then to audit to assess the impact of the strategy early in 2016, but this had not taken place at the time of the inspection.

Activity, current position and impact: A new LSCB multi-agency training programme on neglect was launched in January 2015, and 235 practitioners have received the training so far. This is not yet having sufficient impact on practice, as graded care profiles are still not being used routinely to assess and evaluate the extent of neglect.

In order to address this, the Neglect Strategy Task and Finish Group has been reinstated, led by Nigel Moorhouse Director for Children's Social Care, to drive the relaunch of the strategy and use of the graded care profile. A neglect scorecard has been developed that contains the key measures set out in the strategy and is being used to inform the LSCB on impact of the strategy. Graded care profile training is now a mandatory training course for all ASYEs (Social Workers in their assisted and supported year of employment).

Key strategic managers from children's social care are attending all the Ofsted 'Getting to Good' seminars on neglect to learn from best practice and share with relevant staff. All partners will report on progress against the LSCB business plan priorities in their annual reports, including progress against reducing and tackling neglect.

Next steps – how we will sustain and embed progress: The Task and Finish Group will review the impact of the strategy through the reporting mechanisms that have now been developed and will drive the actions to embed use of the graded care profile, including a relaunch of the strategy and tools.

A multi-agency audit will be conducted to evaluate the impact of this on frontline practice as part of the LSCB audit programme.

154. Develop links with the Local Family Justice Board so that CESCB can monitor how well the needs of children in public and private law proceedings are met.

Background to the recommendation: The LSCB had no oversight of or connection to the Local Family Justice Board, so it could not assure itself that young people's needs were being met in relation to public and private proceedings.

Activity, current position and impact: A report from CAFCASS was given to the LSCB Board in January 2016, and the Board agreed focussed areas for scrutiny in terms of performance. Performance measures are included on the LSCB performance scorecard which are scrutinised every quarter. CAFCASS performance will be reviewed in the LSCB Business Plan and Annual Report.

Nigel Moorhouse, Director of Children's Social Care, is the named link with the Family Justice Board and identifies any issues that need to be brought to the attention of

the LSCB. Update from the Family Justice Board is a standing item on the LSCB Executive and LSCB Board agendas. Regular meetings taking place between area managers and CAFCASS, and there is established and regular communication between CAFCASS and IRO managers.

Next steps – how we will sustain and embed progress: Reports from CAFCASS are on the forward plan for scrutiny from the LSCB Board and LSCB Quality and Outcomes Sub Group.

155: Review the arrangements for monitoring the quality of private fostering work.

Background to the recommendation: The arrangements for case management of private fostering were not sufficiently robust. Private Fostering cases sampled showed delays in responding to notifications, DBS checks, visits and decision making.

Activity, current position and impact: Awareness raising is now routinely carried out and recorded. Materials and posters have been used to support a publicity campaign and are included in a pack which is provided to all social work teams.

Data on compliance with DBS Checks has been compiled to inform the LSCB, which revealed that there are still significant delays in obtaining DBS checks. The lead IRO for Private Fostering is developing a process for obtaining timely DBS checks and management sign off which will be formalised in the Private Fostering policy and procedure.

This year we have nearly doubled the number of privately fostered children and young people we are aware of in Cheshire East, from 6 to 11 new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases.

The LSCB Private Fostering Sub Group has sought previously privately fostered young people's views on service to inform service evaluation and development. The three young people interviewed were very positive about the support they had received from their social workers "They wanted to know what was going on for me, I felt listened to", and reported that they felt cared about and safe. They were all visited very quickly following the initial referral, however the first visit was not used to full effect in that a lot of information sharing and gathering at that point was missed out. All three young people felt this was important they wanted to know they could stay as quickly as possible. Two of the young people expressed concerns about the financial implications their care had on their carers, and said that they didn't like to ask for things like toiletries and make-up and this caused them stress. The young

people felt that process for receiving additional monetary support needed to be dealt with far quicker and advice in this area should be improved. An action plan to improve services based on this feedback has been developed to address these areas.

Performance on Private Fostering is monitored through the LSCB scorecard and a progress report from the Chair of the Sub Group is received by the LSCB Executive.

Next steps – how we will sustain and embed progress: A multi-agency stocktake of private fostering arrangements will be carried out, which will inform the development of a focused Private Fostering Strategy. A multi-agency audit of the quality of casework will be carried out in June and this will inform further service development.

The LSCB Private Fostering Sub Group will respond to any areas for development identified through the multi-agency audits. The private fostering annual report will be scrutinised by the Quality and Outcomes Group and areas for further development will be identified.

156: Improve the influence of CESCB in the work of the Health and Wellbeing Board to ensure that safeguarding is embedded within its priorities.

Background to the recommendation: Strategic links between the LSCB and the Health and Wellbeing Board were not explicit. As a joint adults and children's Board, the children's agenda within the Health and Wellbeing Board was not given sufficient priority.

Activity, current position and impact: The Health and Wellbeing Board (HWBB) is the accountable body for the Children and Young People's Improvement Plan and have received a number of reports on the outcome of the Ofsted inspection and the improvement plan. They have also received a presentation on the LSCB Annual report 2014-15 and business plan for 2015-16.

Key updates from Children's services have been scheduled on the forward plan for the Health and Wellbeing Board to ensure they have strategic oversight and scrutiny of the quality of children's services and the key issues for children and young people in Cheshire East. Other reports around children's issues, including a report on the health of cared for children have been considered by the HWBB.

The Health and Wellbeing Strategy is currently being refreshed, and this will align with the areas of the Cheshire East Children and Young People's Plan, which is already aligned with the Corporate Parenting Strategy and LSCB Business Plan.

A development plan for Health and Wellbeing Board Members has been developed, which includes observing and meeting with key teams and groups. Members of the Board have been canvassed for their training and development needs relating to children's services and responses are currently being collated and will inform the training and development offer to the Board to ensure all members have the necessary knowledge and context to effectively scrutinise the quality of children's services and whether they are meeting the needs of children and young people in Cheshire East.

Next steps – how we will sustain and embed progress: The HWBB will continue to receive regular updates on progress against the improvement plan. The LSCB Annual Report for 2015-16 and Business Plan for 2016-17 is on the forward plan to be discussed at the Health and Wellbeing Board in July. Other reports relating to children's issues are scheduled to go to the board in 2016-17. This will ensure that children's issues continue to be championed at the HWBB and that they are informed and scrutinise key issues in relation to children's services.

157: Develop and implement a coordinated strategy in relation to female genital mutilation so that the impact of multi-agency work within Cheshire East can be evaluated and understood.

Background to the recommendation: The work in relation to female genital mutilation was not yet coordinated. Health agencies recorded the prevalence of incidents but this was not formally reported to the Board.

Activity, current position and impact: It was agreed that this work would be best progressed on a pan-Cheshire basis. A LSCB task and finish group, led by the Named GP, working in partnership with local hospital trusts, has been established to agree and monitor a FGM pathway as part of a Pan Cheshire co-ordinated strategy. The procedure for FGM is currently out for consultation.

Next steps – how we will sustain and embed progress: Launch the FGM strategy across the pan-Cheshire area and evaluate its impact after 6 months.

158: Implement a protocol that outlines when the National Panel should be notified about SCRs and incidents in order to strengthen scrutiny of decision-making.

Background to the recommendation: There were no serious case reviews (SCRs) commissioned in the last four years; those cases considered for SCR had not been referred to the National Panel. This meant that there had not been any external monitoring of the thresholds to undertake a SCR.

Activity, current position and impact: A notification process for when the National Panel should be notified about SCRs and incidents has been developed and launched and is on the LSCB website. The online procedures for SCRs are currently under review on a pan-Cheshire basis.

Next steps – how we will sustain and embed progress: Revision of the online procedures for SCRs to ensure these are clear for practitioners. Plans are underway to commission an independent review of the application of the threshold for cases in Cheshire East and the notification process to critically assess its effectiveness, however this may be subject to change following the Government's review of the LSCB functions including Serious Case Reviews; this is expected in April 2016.