Annual Improvement Progress Report

Self-Assessment against the Ofsted Recommendations

August 2017

Cheshire East Council

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Overview of this Report

This report is a self-assessment of our progress to date against the recommendations from the Ofsted inspection in July 2015. A self-assessment of our progress was completed last year in July 2016. On the basis of this assessment, it was agreed that a number of the recommendations had been met but that our progress against all the recommendations would be revisited in a year's time to ensure that progress had been maintained, and also to evaluate our position relative to the other longer term quality or practice recommendations that had not yet been met.

This report outlines for each of the Ofsted recommendations:

- The **background to the recommendation –** why the recommendation was made and the issues at the time of the inspection
- Our **strengths** – areas where our practice is strong and arrangements are robust and effective
- Any **areas for improvement** – areas where our practice still needs to improve further or we need to strengthen arrangements
- **Next steps** – our plans for how we will continue to address the area of improvement to achieve good and outstanding practice
- An **evaluation** on whether the recommendation has been met

The report is sectioned by:

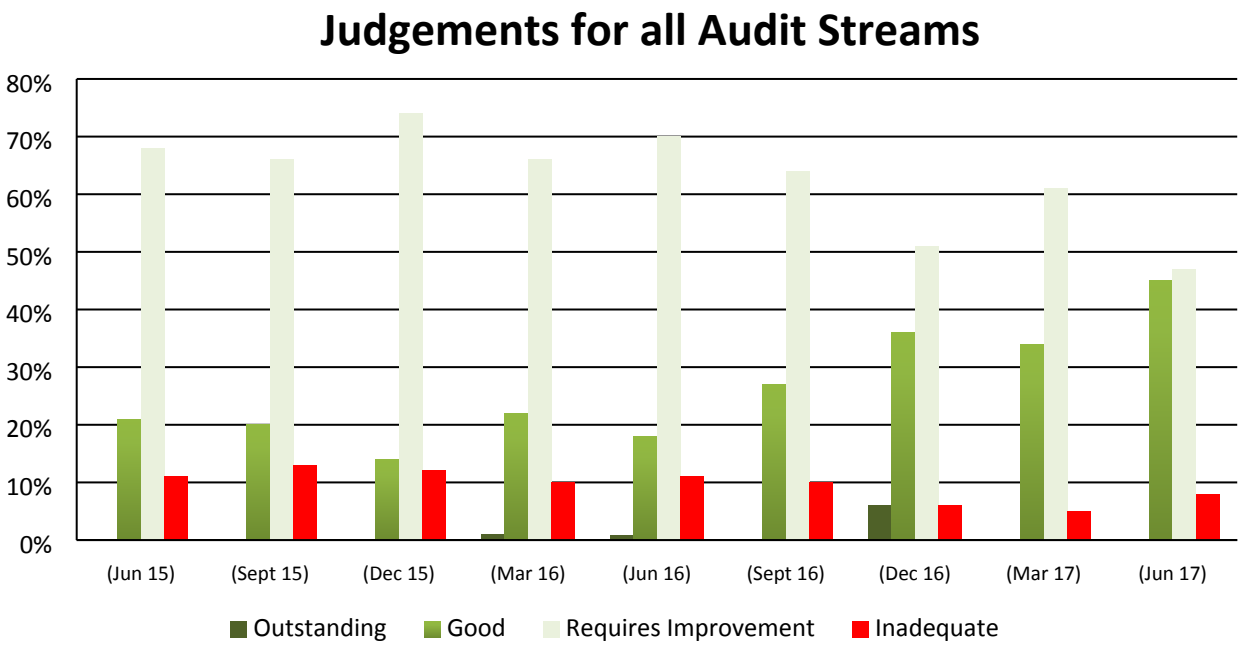
- **Recommendations we are addressing through our Improvement Plan**. These are the recommendations which were not yet met in July 2016.
- **Recommendations we agreed were met in July 2016.** Some recommendations that were agreed as met were agreed to be subject to close monitoring and scrutiny to ensure progress was sustained.

We are now two years on from the inspection period, and the quality of our practice has considerably improved in this time. With this improvement, the focus of our improvement activity has moved from meeting the Ofsted recommendations to achieving our aspirations to achieve the best outcomes for children and young people through high quality practice. How we will achieve this is outlined in our Improvement Plan.

Progress against the eight LSCB Ofsted recommendations will be evaluated and reviewed by the LSCB at the board meeting on 22 November 2017.

Overview of the Quality of Services

We have continued to build on the progress we have achieved so far in our journey, and the amount of good quality practice continues to increase. Our quality of practice as measured through audit has shown a continued positive trajectory over the past year. Overall, audit judgements show an increase in the percentage of cases considered to be good or better (45% cases in Q1 compared to 34% in Q4, and circa 20% throughout the previous year 2016/17), along with a 17% decrease from the last quarter in those cases judged to be inadequate or requiring improvement. This is a significant achievement; this is a massive 32% decrease in cases that are less than good since last year.



Practice is strongest within referral and planning, with 78% referrals, 56% Child in Need Plans, 50% of Child Protection Plans, and 65% of Cared for Plans being judged as good or better in the last audit in quarter 1 (Q1).

Children and young people are continuing to receive the right service to meet their needs; in the last audit, 96% cases showed that the social worker took the right action at the right time to protect the child/ young person and their siblings, and 87% evidenced that intervention had improved outcomes for the child/ young person. A common theme that re-occurred throughout the positive judgements made in this cycle was that social workers shared information and communicated with other agencies throughout their involvement. This promoted good working relationships and a team approach to achieving the best outcomes for children based upon clear expectations of all those involved with the family.

Although the quality of practice continues to improve, overall, the majority of our practice is not yet good, and is not yet at the quality and consistency we want for our children and young people. Plans are in place to continue to drive improvements to practice, including the adoption of **Signs of Safety** which will support us to achieve a cultural change in our practice so we are more child-centred, solution-focused, and respectful and inclusive of families. This will support us to make the step change to consistently good and outstanding practice, leading to improved outcomes for our children and young people.

A wealth of research is available which shows that Signs of Safety achieves improved outcomes for children. It is widely recognised internationally as the leading approach to child protection casework, and has been commended by Ofsted. Signs of Safety is a framework for social work that supports strong risk assessment and analysis of the impact on the child/ young person, and co-production of plans with families based on the wishes and feelings of children and young people. Through developing solutions with families, Signs of Safety supports families to achieve outcomes that they can sustain in the long term.

For more information on our adoption of Signs of Safety please see our Signs of Safety Strategy.

Driving Improvements to Practice

Robust arrangements are in place to ensure managers at all levels are regularly informed on and held to account for the timeliness and quality of their service, enabling effective action to be taken in response to our areas for improvement. A consistent finding from all inspection and peer review activity has been that we know ourselves well. These arrangements include:

- **A comprehensive audit programme** conducted by senior managers and all team managers across the service, which includes hearing the views and experiences of children, young people and families. Findings are collated for each quarter. Our audits have increasingly moved to focus on the quality of practice and outcomes achieved for children and young people as we have achieved increasing consistency in compliance with our practice standards and statutory requirements. This focus on quality is continuing to support learning and reflection on good practice. Audit findings are communicated to all Children and Families staff through the audit bulletin, and are scrutinised by the Children's Social Care Leadership Team, Children and Families DMT, and the partnership through the LSCB.
- **Monthly IRO Audits;** deep dive thematic audits on specific topics highlighted as areas for further exploration from our performance information as scrutinised in the Performance Challenge sessions. These audits include gaining feedback from partners on the quality of practice. The findings are shared with the LSCB Safeguarding Children Operational Group (SCOG) where there are implications for partnership working, and this group has been responsible for improving processes and practice across a number of work areas. Findings are scrutinised by the Children's Social Care Leadership Team, Children and Families DMT, and the partnership through the LSCB.
- **LSCB Multi-agency Audits;** regular thematic audits which drive improvements to partnership working and are scrutinised through the LSCB.
- **Supervision audits** review the quality of supervision. These audits are complemented by a supervision and PDP tracker which tracks compliance with regular supervision and the PDP process.
- **Performance Challenge Sessions**, supported by a full suite of performance information critical to each service down to individual level that is provided to team managers on a fortnightly basis.
- **Performance Trackers** giving managers oversight of key areas of practice and children and young people who are most at risk of drift or delay.
- **IRO Practice Alerts and Good Practice Notifications** challenge poor practice, including partnership practice, and recognise good practice.
- **Children in Need and Child Protection Feedback Survey, and Compliments, Comments and Complaints report** ensure children, young people and parents/ carers views are heard and inform service planning and development. Findings ae shared at Management meetings.

- **Annual Social Work Staff Survey** ensures the views of the workforce are heard and responded to so we can effectively support, develop and retain staff. The Practice Champions Group are leading the creation of an action plan in relation to the results from the latest survey to ensure that solutions in response to practitioner issues are practitioner led.
- **The Children and Families Scorecard and Corporate Parenting Scorecard** ensure key performance information is scrutinised by elected members.
- **Regular reports to Partnership Boards and internal scrutiny.** Clear reporting structures are in place and regular updates on service quality and performance are scheduled and received by Children and Families DMT, Children and Families Overview and Scrutiny Committee, the LSCB and relevant sub groups, Corporate Parenting Operational Group and Corporate Parenting Committee, and the Health and Wellbeing Board.
- **LSCB Quality and Outcomes Sub Group Deep Dives** around partnership issues are driving improvements to partnership practice.

The majority of these have been in place prior to the inspection in July 2015, are fully embedded and have been shown to be effectively driving improvements to practice. A range of other mechanisms are in place which have also been shown to be successfully driving improvements to practice. These include:

- **Involving children and young people in service design** and development through the work of our partnership boards
- **Practice and Performance Workshop**s, where professionals are involved in developing our service and good practice is shared
- **Practice Champions**, who champion good practice within their teams, develop resources for professionals and troubleshoot and respond to issues raised by professionals.
- **LSCB Safeguarding Children Operational Group (SCOG)** which has been driving developments to practice as a partnership.
- The mandatory **Core Training Offer** for social workers and managers, linked to progression
- **Masterclasses** to support specific areas of practice
- Our successful **Recruitment and Retention Strategy** and steering group which has supported us to build a stable workforce.

Summary of our Self-Assessment against the Ofsted recommendations

The evidence presented in this report demonstrates that we have now met the following recommendations:

- **Rec. 2:** Ensure the challenge provided by child protection chairs and independent reviewing officers addresses drift and improves planning for children
- **Rec. 3:** Ensure that supervision is reflective, challenging and consistently focuses on continual professional development
- **Rec. 6:** Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded
- **Rec. 10:** Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded

The following recommendations which were agreed as met in July 2016 remain met:

- **Rec. 11:** Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays
- **Rec. 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
- **Rec. 15:** Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice
- **Rec. 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
- **Rec. 13:** Ensure audit arrangements have a sharper focus on looked after children
- **Rec. 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 information provided through the electronic recording system so that managers have effective oversight of frontline practice

The <u>CSE element</u> of this recommendation has been met:

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

All elements of this recommendation have been met, except the use of family group conferences:

- **Rec. 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

Recommendation 4 will be met once timeliness is restored following recruitment to the new staffing structure in Early Help Brokerage:

- **Rec. 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.

Significant progress has been achieved for the following recommendations, although the majority of practice is not yet **consistently good** so these recommendations are not yet fully met:

- **Rec. 5:** Ensure that strategy meetings and decisions are informed by relevant partner agencies
- **Rec. 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.
- **Rec. 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.

These are key elements of social work practice and will remain a key area of focus for further development. Plans are in place to continue to drive progress in these areas, including the adoption of Signs of Safety as our way of working with families.

The following recommendations remain areas for improvement and **require dedicated focus**:

- **Rec. 12:** Improve the timeliness of initial health assessments so that children who become looked after have their health needs assessed within the expected timescales.
- **Rec. 7:** Strengthen frontline practice to ensure effective action is taken to support children who go missing
- **Rec. 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 improving the use of family group conferences so that all possible options for children are consistently explored. **Whilst we have decided not to implement a traditional Family Group Conferences model we will continue to strengthen core social work practice by using Connected Person's meetings.**

Proposal for Improvement Monitoring Activity

Extensive activity has been undertaken which has resulted in significant and sustained progress. A range of mechanisms are in place to support service development activity which are effectively informing managers on quality and supporting them to effectively drive change. The quality of practice continues to improve.

Cheshire East has been on a four year improvement journey since our inadequate inspection in March 2013. Since this time, progress against the Ofsted recommendations and the quality of Children's Social Care services have been scrutinised and reported separately, and dedicated forums and scorecards have been developed to support challenge on progress in these areas. The majority of recommendations have now been met, and we are in a significantly stronger position than we were in the last inspection in July 2015. Over time, arrangements have been increasingly brought within business as usual service development activity, and this activity has appropriately moved to a focus on achieving good quality practice rather than meeting the Ofsted recommendations or measuring compliance with these.

The quality of our practice still requires further improvement as it is not yet consistently good. There is a significant body of work devoted to ensuring this is achieved, including the adoption of Signs of Safety as our way of working, work to improve the quality and timeliness of court work, and work to ensure robust assessments of family and friends arrangements. Strong plans are in place to support this work, and there are existing arrangements for monitoring and driving progress in these key areas, for example through the Signs of Safety Project Board and Court Work Task and Finish Group. This work can and is being effectively driven through existing arrangements.

Effective oversight of the quality of Children's Social Care services is in place from team management level at the Performance Challenge Sessions, through to directorate level within the Children and Families Directorate Management Meetings. External scrutiny and challenge is provided through the Children and Families Overview and Scrutiny Committee, LSCB and sub groups, Corporate Parenting Committee and Operational Group, Children and Young People's Trust and Health and Wellbeing Board. Audit reports and scorecards are comprehensive and demonstrate the current quality of services.

Therefore, it is recommended that improvement activity in Children's Social Care becomes fully incorporated within business as usual processes as **service development** rather than improvement (as recognition that our practice is increasingly good quality and that our aim is to continually develop this), and is no longer reported separately within improvement monitoring reports to dedicated monitoring sessions. Under this proposal, dedicated activity to the meet the outstanding recommendations would be incorporated within the Children's Social Care Service Plan rather than a dedicated Improvement Plan.

The vast majority of arrangements are now within business as usual processes. Items which are additional and specific to improvement monitoring activity, and the proposed replacement arrangements under business as usual are outlined below:

Current Improvement Monitoring	Proposed Business as Usual
Improvement Challenge sessions with the Director of People's Services	Performance Challenge Sessions for Children and Families Directorates
Improvement monitoring reports	Audit reports, scorecards, reports on service development activities
Children's Improvement Plan	Service Development Plan
Improvement Plan Scorecard	All the measures on this scorecard are already contained on other scorecards

The monitoring arrangements for the recommendations which have not yet been met are outlined in the appendix.

Review of the Ofsted Recommendations from the Inspection in July 2015

Recommendations we are addressing through our Improvement Plan

Quality of Practice

2	Ensure the challenge provided by child protection chairs and independent reviewing officers addresses drift and improves planning for children (paragraphs 37, 84)

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.

Strengths

The effectiveness of Child Protection (CP) IRO challenge in cases of drift and delay is scrutinised and robustly monitored through Performance Challenge Sessions. The number of children on longer plans has reduced, which shows that challenge is being effective in addressing drift; in Q1 2015-16 last year, 11% of Child Protection Plans had been open for over 15 months, compared with just 5% in June 2017. The CP IRO's are currently devising a set of measures to support them to evidence the effectiveness of their challenge.

Child protection review conferences continue to be held within timescales. Performance on this has remained consistently high since Q3 in 2015-16 when 98% of reviews were held in timescales, the current figure remains at 98%.

The format of CP Conferences has also been changed to ensure the focus is on the impact for the child. The Making Children Safer Conference model (based on Signs of Safety) is supporting more evidenced decision making and SMARTer Child Protection Plans. Evidence from audit suggests that this model is having a positive impact on the effectiveness of plans and is reducing the number of children and young people subject to repeat plans. Through using this model, Child Protection IRO's, Social Workers and partners are becoming more skilled at developing effective Child Protection plans and measuring their impact on children and young people. This demonstrates the impact that Signs of Safety practice has made to children and young people and indicates the further scope for improvements to the quality of our practice once we adopt this approach across all of our practice.

Child Protection IROs ensure that parental motivation and capacity to change is a central consideration in all Child Protection Conferences and planning, and that positive change for the child or young person, which the family can sustain, is clearly evidenced where cases are stepped down. IROs ensure that there are clear contingency plans in place when cases are stepped down from Child Protection; this supports timely and appropriate decision making for the child if their circumstances begin to deteriorate.

In the last audit in Q1, there was evidence of IRO scrutiny and oversight in 96% cases. Audit demonstrates that the quality of child protection plans have improved; they are child centred and increasingly SMART. 50% Child Protection plans were judged as good or better in the last audit in Q1. The lived experience of the child is increasingly coming alive within conference through the chairs asking 'so what' questions and through the effective use of advocates.

IROs complete themed audits every month to support learning and developments to practice. These are actively supporting improvements to practice, and themes are repeated to assess the impact of service changes on practice. For example, a follow up audit of Strategy Discussions took place during September - October 2016, which reviewed the impact of subsequent service improvements on the quality of strategy discussions, following the initial audit in January 2016. The repeat audit showed the impact of awareness raising activity around strategy discussions. Multi-agency involvement had significantly improved; 55% of cases in September/October 2016 involved participants from at least one other agency apart from the Police, whereas in January 2016 this was true in only 12.5% of cases. The significant body of work underway to improve timeliness for children and young people in public law proceedings (outlined under recommendation 6) was driven by the findings of an IRO audit on PLO.

The Practice Alert process is now embedded for social workers and multi-agency workers. During 2016/17, IROs raised and resolved 122 issues informally with social workers and their team managers through this process. The robust IRO challenge and escalation of issues to improve outcomes for children has been embedded and accepted as an integral part of the care planning and case review process.

IROs track and provide additional scrutiny for children and young people who are on a second or subsequent plan through:

- Tracking via supervision and in monthly performance challenge sessions
- Monthly themed audits to identify learning points, themes and issues
- Effective gatekeeping at the point of conference request
- Robust contingency planning
- Appropriate escalation. The IRO escalation process has been further embedded. The quarterly IRO escalation reports are shared with managers and senior leadership team, including any emerging themes.

Cared for IROs continue to actively track the progress of children's care plans, particularly when they are in care proceedings, and appropriately escalate any cases that are not progressing within the child's timescale. Timely notifications and sharing of court documents/ orders has improved following the involvement of the Cared for IRO's in in the PLO/ Court Work and Proceedings Procedures Working Group.

The majority of Cared for Children's Plans are now good quality or higher (65% in the last audit in Q1). This is a considerable improvement.

The Cared for IROs have initiated a Task and Finish Group to improve key elements supporting placement stability, including assessments, matching, support, management of disruptions, and the tools and reports used within these processes.

Areas for improvement

Arranging reviews and the endorsement of final care plans at the end of the care proceedings still remains an area for further improvement. However, this has been improving and there has been a specific focus on good practice regarding planning and timescales within care proceedings. IRO's are participating in a specific work stream within the PLO/ Court work Task and Finish Group and this is helping to ensure there is sufficient time for IRO scrutiny and review/endorsement. Across the North-West region we have been achieving better outcomes on this aspect in comparison with some other IRO services.

Next Steps

The CP IRO's are currently devising a set of measures to support them to evidence the effectiveness of their challenge.

In line with Signs of Safety, CP IROs will be requiring all partners to set timescales for parents and carers on the likely duration of plans from September 2017. This will support timely planning for children and young people and makes it clear for parents and carers what we expect and when we think this should be achieved by.

For the Cared for IRO Service, service development activity will focus on:

- Understanding, addressing and reducing placement disruptions for our Cared for Children, with a strong focus on the prevention and management of placement instability.
- Working with the Virtual School on understanding trends and methods of addressing the needs of underachieving cared for children and young people,
- Closer co-operation with the teams involved with the SEND agenda, in relation to embedding consistent processes for the child between their EHCP reviews and statutory case reviews, in line with the relevant national practice guidance,
- Exploration of the impact of implementation of the joint homelessness protocol in cases of cared for young people age 16-17 who ask for support from local authority,

Evaluation

This recommendation has been met.

Child protection review conferences are consistently being held within timescale.

IRO oversight and challenge is now well embedded and accepted as an integral part of the care planning and case review process. IROs are challenging practice to ensure that plans are child-centred, good quality, and drift and delays are prevented. The quality of plans has improved; plans are increasingly child-centred and SMART, and there is now a much higher proportion of work that is good or better quality. IRO thematic audits are effectively driving improvements to practice. Developments to Child Protection conferences and IRO

involvement in service development has led to improvements to the quality and timeliness of planning for children and young people.

IROs are challenging poor practice and potential drift effectively using Practice Alerts. The number of children on longer plans has reduced, and there is a robust process in place where these cases are closely scrutinised on a monthly basis to prevent drift and delay and ensure plans are appropriate.

3	Ensure that supervision is reflective, challenging and consistently focuses on continual professional development (paragraphs 33, 130).

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 (PDPs) 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.

Strengths

Bespoke management training for team managers is delivered to ensure they have the skills and knowledge they need to support, inspire and challenge their teams to always put children and young people first. A workshop on Reflective Practice for Managers took place in March 2017 which included reflective supervision and developing reflective teams. Supervision training for managers and for supervisees is part of the mandatory core training offer. Constructive challenge is modelled through the Performance Challenge Sessions.

There has been a focus on ensuring that all social workers receive regular, good quality supervision which supports reflection and learning so we can effectively support our children and young people. A Supervision Tracker is in place to track the frequency of supervisions and this is monitored and challenged in Performance Challenge Sessions. This tracker also includes PDPs to ensure and monitor compliance with this process.

Supervision audits are being completed on a regular basis to monitor and inform improvements to the quality of supervision. The last supervision audit in March 2017 found that the majority of supervision records were graded as good or better (69%). These audits demonstrate that supervisees speak positively about supervision and found it was a safe place to develop and challenge practice.

> My experience of supervision has been very positive. It is regular, not rushed and very reflective. Lots of opportunity to discuss cases as well as team issues, training, more general career issues etc. I find my team manager very supportive and we can have good, open discussions. There is nothing else that I would like from it that is not already been provided.

The next supervision audit report is currently being compiled and the regular nature of these is creating a more representative picture regarding areas of supervision that are working well and areas for development. Personal development plans are now much more embedded and are being used to drive practice improvement. 81% had a PDP in place in the supervision audit.

In the Social Work staff survey, the vast majority of respondents (89%) rated the support from their line manager as a seven or higher on a scale of 0-10 where 10 is the support is excellent, they can always ask for support when they need it, and their manager cares about their development, and 0 is that they do not feel supported. 34% rated it as a 10. The comments from this survey show that social workers are receiving regular supervision which is supporting their professional development.

Supportive manager who will talk through anything, cares about progression and about ensuring I am happy. Wants to help and encourage and ensure I develop the necessary skills. Any worries, concerns or areas of improvement I have requested before has been taken on board and put into practice. Has even sat with me and looked over different areas such as assessments, care plans, chronologies etc. A terrific manager.

Support is thorough and clear guidance is provided which also encourages professional development

A number of people in the survey suggested the use of group supervision as a development tool to enhance the opportunities for learning and reflection across the team. This will be introduced with Signs of Safety.

Variety of courses available to suit staff at all levels in their career

Fair, approachable, assists in reminding about performance, supervision, encourages development

A core training offer for Social Workers and Managers has been developed which is ensuring that the training and development trajectory is clear and that these needs are being met. Specialist training in relation to key areas for practice improvement, for example court skills, has been commissioned and is being rolled out to teams. In the social work staff survey, 68% respondents rated the training and the development opportunities they receive as a seven or above with 10 being excellent and 0 being poor.

Quality of training in Cheshire East is very good

Court skills is very good.

They are wide ranging, frequent and encouraged

Training and development opportunities have improved greatly over the six years I have been with the

Next Steps

The Supervision Audit policy and processes will be reviewed and aligned with Signs of Safety. Signs of Safety will support the further development of reflection and challenge within supervision through the introduction of group supervision facilitating joint learning and sharing of practice. The impact of this will be monitored through future Supervision Audits.

Management training continues to be developed; from January 2018 we will be linking in with Staffordshire University to access the Aspiring Managers module.

Evaluation

This recommendation has been met.

Supervision is being carried out to a good quality which is reflective, challenging and is supporting professional development. A comprehensive training programme is in place, and the use of PDPs is now much more embedded. The introduction of Signs of Safety and the

Team Manager Leadership programme will support continued improvement of supervision. The impact of this will be measured through future supervision audit reports.

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 (paragraph 25).

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.

Strengths

Since the inspection we have established the Early Help Brokerage Service. This service is dedicated to progressing contacts that do not meet the threshold for social work intervention. This specialist service was designed to ensure that these contacts are progressed swiftly, and the right support is identified to meet the needs of the child or young person.

A comprehensive review and restructure of the front door has taken place including mapping the pathways from referral to allocation to ensure families receive a timely service. Within the redesign, we have increased the support available to partners undertaking CAF to ensure that partners are supported to develop the confidence and skills to lead high quality work with families. This is a significant additional resource.

A work plan for the LSCB Early Help Sub Group has been developed and implemented to drive developments across the partnership and ensure we support families at the earliest possible stage. The work on the group has included the development of a new Early Help Strategy. The levels of need are currently being refreshed and are out for consultation with partners. These will be discussed in detail at the LSCB in September 2017.

The Common Assessment Framework (CAF) team has been re-established and CAF training is to be relaunched with partners. Regular CAF audits have been re-instated and are being reported to the Local Safeguarding Child Board (LSCB) to identify areas for partnership improvement. The last prevention audit in Q1 found that all CAFs audited were good or better quality.

Areas for improvement

The impact of the restructure of the Integrated Front Door has had an impact on the timescales for decisions made within Early Help Brokerage. Under the new structure, more of the triage function takes place in the Brokerage service. Additional staffing to support this increase in work is included within the new structure, but these new staff are not yet in post so this has had an impact on timescales. The standard for decisions in relation to Early Help cases is within 3 working days; for Q1 56% of cases had a decision and were passed on to services within that timeframe, which is a significant reduction from previous timescales. However 79% were within 5 working days. Timescales are expected to return to the previous consistently high levels once the new staff are in place.

Next Steps

We will continue to closely monitor the timeliness of decision making at Early Help Brokerage to ensure this returns to the previously high levels.

A review of Early Help services is underway to ensure that we meet the needs of our children and young people early and prevent escalation. Signs of Safety will be adopted across early help services to ensure we have a consistent approach for working with families.

Evaluation

Once timely performance returns, this recommendation has been met.

Structures are in place to ensure that children and young people who do not meet the threshold for social work intervention have their needs considered promptly and they are referred to the right early help service. The recent restructure in the front door has impacted on the timeliness of decision making, but performance is expected to return to previously high levels once additional staff are in post. Performance is monitored on a monthly basis.

5	Ensure that strategy meetings and decisions are informed by relevant partner agencies (paragraph 27).

Background to the recommendation

In the majority of cases seen, strategy discussions were telephone conversations between a team 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.

Strengths

An audit of strategy discussions in January 2016 showed that only 13% of discussions were multi-agency (involved at least one other agency other than the police). Considerable improvement has been achieved since then as a result of awareness raising activity and workshops.

In the last audit in Q1, 58% strategy discussions and section 47s were judged as good or better. A deep dive on strategy discussions was completed by the Head of Service in May 2017 to challenge managers on non multi-agency discussions. This deep dive found a number of good examples of multi-agency discussions, and for pre-birth strategy discussions the vulnerable families midwife was consistently involved. However it also revealed that practice is still variable in relation to multi-agency inclusion. There were 18 discussions found where strategy discussions were just discussions between the police and Children's Social Care but should have involved other agencies.

An IRO repeat audit of Strategy Discussions was undertaken during September to October 2016. This follow up audit reviewed the impact of subsequent service improvements on the quality of strategy discussions. The audit outlined the following strengths:

- Decisions to proceed to a Strategy Discussion were more considered. Improved information gathering was informing decision making, 32% cases were thought to require more information before a decision was made compared with 50% in the previous audit.
- Multi-agency involvement in Strategy Discussions had improved from 13% to 55%.
- This had resulted in improved decision making. There was decrease in follow up strategy meetings and an increase in the proportion of cases progressing to a S47 enquiry (46% compared to 38%). Very few cases proceeded to strategy discussion where this may not have been necessary. In the previous audit, auditors disagreed with the decision to proceed in 44% cases, and this had reduced to just 11%.

In response to the audit findings, the LSCB Safeguarding Children Operational Group (SCOG) established a Task and Finish Group which reviewed the current process for requesting attendance at strategy meetings, and obstacles in achieving multi-agency attendance. An action plan has been developed to address this and a new process for requesting attendance from partners when a strategy meeting is called has been put in place.

Quality assurance on strategy discussions is currently being undertaken by jointly the Service Manager for the front door and the police.

Areas for improvement

Multi-agency involvement in Strategy Discussions still requires further improvement.

Next Steps

A repeat IRO audit on Strategy Discussions will take place in October 2017.

Regular Police Liaison meetings take place and Strategy Discussions are to be a standing agenda item. We are currently reviewing the process for Strategy Discussions that take place shortly after referral to see if this could take place in the front door with the involvement of the integrated multi-agency team.

A task and finish group is currently reviewing how lack of invitation or attendance can be challenged by partners, and whether themes and trends can be collated and reported to the LSCB Executive. Work is also being undertaken to support better use of video conferencing across the partnership to enable all partners to participate.

Evaluation

This recommendation has not yet been fully met.

Multi-agency involvement in strategy discussions has significantly improved and work continues as part of our continual business improvement to enhance the quality and involvement in these discussions. Progress will be evaluated in the audit in October 2017.

6	Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded (paragraphs 21, 23, 25, 33, 50, 55, 59, 86, 107).

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. Recording was not always detailed enough to show the benefits of contact with families for cared for children and young people.

The work presented to courts was of variable quality.

Strengths

All the cases in the last Preventative services audit in Q1 were judged as good or better which evidences that the quality of CAF has improved.

Audit demonstrates that the quality of work at referral is good, with 78% of cases being judged as good or better in the latest audit cycle in Q1. 100% consultations in the audit in Q4 (the last audit to collect performance against this measure) considered historical information. Performance on this has been consistently high since Q3 in 2015-16. Audit has also shown that management decision making within ChECS has been consistently strong over the last two years.

Measure	Q4 15/16	Q1 15/16	Q2 16/17	Q3 16/17	Q4 16/17
Standard for management decision making and recording met at ChECS	100%	100%	100%	100%	100%
History considered at ChECS	80%	100%	80%	70%	100%

Managers are scrutinising work, in the last audit in Q1 there was clear evidence of managers actively scrutinising and authorising plans in 97% cases, and the rationale for management decisions was clear in 86% cases.

The quality of practice and recording has significantly improved since the inspection. 45% cases were judged to be good or better in the last audit Q1 compared to just 21% two years

ago. Improvements in the number of cases judged to be good or better has seen a steady rise over the last year. Audits have shown that the quality of case recording met the practice standard for the vast majority of cases over the last year:

Measure	Q4 15/16	Q1 15/16	Q2 16/17	Q3 16/17
Quality of case recording - CIN/CP	78%	83%	83%	100%
Quality of case recording - Cared for	83%	90%	100%	100%

The core training offer for Social Workers and Managers has been developed to embed good quality of practice and ensure that the whole workforce has the skills they need to deliver this level of service. This includes training on producing good quality court reports for ASYEs. Specialist Court Skills training has also been commissioned to support staff to enhance the quality of their court work.

A large body of work is underway to support timely and good quality court work. A workshop on improving our processes around Public Law Proceedings has been held focusing on making our action more timely for children and young people, and an action plan has been established, which is being delivered by task and finish groups. The action plan covers the following areas:

- Care Proceedings Policy and Procedure
- Workforce development
- Working effectively with the Safeguarding Unit
- Achieving positive outcomes for children
- Assessments and permanency planning

As part of this work:

- A new policy has been developed to ensure expectations on the timescales for Legal Advice Meetings (LAMs) and the completion of parenting assessments within the Child Protection Process are clear.
- Service Managers are screening requests for LAMs to ensure they are timely and that there is a clear plan in place for the child.
- A review of the Pre-proceedings letter and contents has taken place to ensure there is consistency regarding the use of the chronology and contract of expectations.
- The timeliness of initial PLO meetings is being monitored and RAG-rated through the court tracker, this information is monitored through the legal liaison meetings and performance challenge sessions.
- Cared for IROs are overseeing the endorsement of the final care plan, and weekly updates on the court and LAM trackers are being disseminated to the whole IRO team. The Cared for IRO manager attends Permanence Tracking meetings to scrutinise the progress of court work in relation to children achieving permanence as well as when discharges of care orders are needed.
- Representatives from Legal Services and Children's Social Care have attended Team Meetings with IRO's to provide updates regarding the PLO work within Cheshire East and developments in case law.

- 'Lessons Learned' meetings between children's social care and legal services have been introduced to review key cases where the outcome we expected in court was not achieved to identify learning and any areas for improvement
- An updated Legal Advice Meetings document has been implemented regarding decisions on applications to court

Areas for improvement

Recording is now much stronger than at the time of the inspection. We still need to improve how we evidence improved outcomes for children which we will support through the adoption of Signs of Safety.

Next Steps

Work is underway to align our forms with Signs of Safety so that they support best practice, and streamline our reporting requirements.

Work on creating a new Preventative Services Case Work and Recording Standards Guidance is underway, which will clarify expectations for staff and support increased consistency in where information is recorded in EHM.

Delivery of the court work action plan will continue, including the development of a comprehensive Care Proceedings Procedure including timescales and the role of specialist teams, along with a workflow for Legal Advice Meetings, Pre-proceedings and Care Proceedings, and the review of the Pre-birth procedure to ensure it includes timescales in respect of court process.

Evaluation

This recommendation has been met.

The quality of practice and recording has improved significantly since the inspection as shown through the audit judgements. Continued improvements to the quality of practice and recording will be continued to be supported through the regular audit cycle and adoption of Signs of Safety.

7	Strengthen frontline practice to ensure effective action is taken to support children at risk of child sexual exploitation and those who go missing (paragraphs 41, 42, 58, 175).

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.

Strengths

Guidance for practitioners on how to complete an effective return home interview has been completed and is available on the LSCB website.

The Missing from Care Focus Group brings together multi agency professionals from residential care, housing, health, Children's Social Care Care and the Integrated Missing from Home and CSE Team. The Group shares information, develops strategies and identifies key areas for future planning. During this process the group have:

- Created consultation tools for child/ young people and parent attending Trigger Missing Level 1 or 2 meetings to ensure that they are fully informed about the process and their views are captured should they choose not to attend.
- Updated relevant templates for recording actions during these meetings, processes for recording Return Interviews and Trigger Meetings on the child's ICS Record and co-designed a relevant report to monitor the trends/ figures.
- Identified gaps in Foster Carer knowledge around Missing from Care which has led to the Integrated Missing from Home and CSE Team delivering some information and awareness sessions with the fostering team and foster carers.

The impact of this work has been:

- Better awareness of Social Workers and carers which has led to more adequate support to children who go missing and the purpose of the Return Home Interview.
- A consistent approach to increasing child and parent ownership of risk management and action planning prior/ during the Level 1 and 2 meetings.
- Consistency of agenda and records for these meetings, which are available for scrutiny and audit as well as data available for reports within a dedicated ICS workflow.
- Data reports are available for analysis at challenge sessions for both fieldwork and IRO services to support enhanced planning and decrease the rates of children going missing.

All CSE Screening Tools completed in the local authority are initially screened by ChECS to ensure the child is safeguarded at the right level and then by the Integrated MFH and CSE Team to ensure that advice and guidance can be provided to professionals at an early stage. This is also used as an opportunity to feedback on the quality of the screening tool to acknowledge good practice and improve this. A good practice example of a completed screening tool is available on the LSCB website. Due to the success of the CSE Operational Group, use of the CSE screening tool is now embedded. The quality of CSE screening tools has increased across the partnership following the training and consultation provided by the CSE and MFH team.

Staffing within our social work teams is now stable and mandatory CSE and MFH training is provided through the Core Training offer. The quality and content of the LSCB CSE training has been reviewed in partnership with young people to ensure that professionals receive the right messages to influence and improve their practice in a way that engages young people. Basic, targeted and bespoke training is available through the LSCB. The CSE and MFH Team have delivered workshops on completing CSE Screening Tools based on a need-led approach through the identification of themes and trends across the local authority, and have delivered a monthly drop-in at each of the three Children's Social Care sites to improve working relationships with Social Workers and to provide ongoing support in robust planning for children at risk of MFH and CSE.

A health assessment tool and referral pathway has been developed to ensure all Children and Young People in Cheshire East who are flagged due to a risk of CSE have a robust assessment of all of their holistic health needs. A process is in place for ensuring that young people with vulnerabilities in respect of CSE are transitioned between Children's and Adult's Social Care and there is a strengthened relationship with Adult's Social Care.

The Children and Families Overview and Scrutiny Committee appointed a Task and Finish Group to investigate the adequacy of the Council's arrangements to protect young people in Cheshire East from sexual exploitation. The group undertook different stages of work, including visits to services and observations of meetings. The group met regularly during 2016 and presented their final report and recommendations to Cabinet in January 2017 where the recommendations were accepted. An action plan is in place in response to the findings.

New links with the CSE team and Education Welfare Support have been established to ensure that accurate and timely education attendance information is made available on the CSE tracker. Although this link is new, early indications of a positive impact are evident. This will however need to be embedded to provide accurate feedback.

Within Local Policing Units (8 across Cheshire) Child Sexual Exploitation is prioritised and considered together with priority threat risk and harm matters at "Fast tac" meetings every two weeks. During these meetings intelligence is shared and gaps are identified to ensure that the threats can be addressed and minimised. Police Community Support Officers act as the eyes and ears of local policing and a key role within each of the LPUs following this process is the deployment of PCSOs. Where locations and individuals are identified as having potential for involvement in CSE activity, PCSOs are deployed to those areas at the relevant times to gather and report local intelligence enabling safeguarding activity to be taken.

There is closer partnership working between the Integrated Team and Police Local Units through close working with CSE SPOCS in each policing area. Links are being considered

between children who go missing and their wider networks. A Greater Manchester Police Operation took place due to intelligence shared by the CSE and MFH Team following disclosures made during return home interviews.

The CSE and MFH Team have worked closely with partners including police, Youth Prevention Service, Youth Offending Service, Youth Support Service, Health, Housing, Probation and Children's Services to map out areas and people who are of concern to groups of vulnerable children and young people in Cheshire East to ensure robust multi-agency responses to reduce ongoing risk.

Disruption activities are a key area of focus of the team in order to prevent offences taking place and to keep children safer in the local authority. One key disruption tool that is utilised in Cheshire East is the issuing of Child Abduction Warning Notices (CAWNs) where a person of concern is having regular contact with a child without parental permission, particularly when a child is frequently missing from home or care. Disruption techniques do appear to be being used at an earlier stage by police and partner agencies which are key in ensuring that concerns do not escalate to the point of requiring Child Abduction Notices (CANs). In addition to CAWNs, other disruption tactic used by police in this period included strict police bail conditions, restraining orders and direct partnership working with licensing.

Areas for improvement

A recent audit in April 2017 of cases where a return home interview from the CSE and MFH team had been declined by the young person showed that for only 22% (4) of these cases the interview had been carried out and recorded by the social worker. However only two of these cases used the Pan Cheshire Return Home Interview form. Notification of Decline forms sent by the CSE and MFH team to Children's Social Care were being recorded as return home interviews which indicates that the information within these is not carefully considered. Therefore use, recording and completion of return home interviews still requires improvement. Missing from Home Risk Assessments were also not consistently evident on the child's record.

Next Steps

The CSE and MFH team will deliver workshops around analysis of risk, developing SMART plans and the MFH Protocol for Social Workers to support completion of high quality return interviews and ensure that information from these interviews informs planning. The CSE and MFH team will inform Team Managers of Service Declines at regular intervals and for those in care this will also be sent to the Safeguarding Unit for additional IRO oversight to support improvements to practice. Activity to support improvements to the quality of assessment and planning are outlined under recommendations 8 and 9.

Evaluation

The CSE element of the recommendation has been met.

The quality of practice has improved since the inspection, and the CSE and MFH team, LSCB Training and the core training offer is effectively supporting the workforce to develop their skills in relation to working with young people at risk of CSE. CSE is being recognised and responded to across the partnership.

Links between children and young people are being explored and appropriate action is being taken.

Ensuring return home interviews inform planning remains a key area for improvement.

Findings from return home interviews are not always consistently used to inform planning. Return home interviews are not consistently completed by social workers when young people decline an interview from the CSE and MFH service.

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 (paragraphs 29, 30, 51, 54, 59, 82, 98).

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. Timescales for completion of assessments were not always adhered to.

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.

Strengths

There has been considerable activity within Children's Social Care to increase the quality of Social Work assessment including:

- **Masterclasses**, which continue to be offered on a regular basis, these have been well attended so far. Masterclass workshops have been held on:
    - Assessing Parental Capacity to Change
    - Exercising Professional Judgement
    - Parenting Assessments
    - Engaging with Birth Fathers
- **Workshops** focussing specifically on the use of change models in assessment.
- The appointment of **temporary Independent Parenting Assessors** (IPA's) to provide modelling and support to Social Workers to improve practice.
- CP IRO's have placed an increased **emphasis on change theory** within conference discussion and decision making in order to support understanding of parental capacity to change.
- A **review of the parenting assessment template and tools** has been completed. The Parenting Assessments Masterclass is now embedded as part of the routine training offer for Social Workers. This is to ensure parenting assessments are timely, good quality and used to inform decision making regarding the child and parents' capacity to change.

In order to consider the impact of focused activity in relation to parenting assessments, an IRO Thematic Audit on Parenting Assessments, specifically regarding parental motivation and capacity to make sustained positive change, was undertaken during January – March 2017. The auditors specifically looked for evidence of change models being used. Compared with previous themed audits completed by the CP IRO's during 2016, which identified that parenting assessments were rarely completed on cases prior to care proceedings and that parental motivation and capacity to make sustained positive change was in most cases not considered either within parenting assessments or child protection reports, this audit had positive findings:

- 55% of assessments clearly identified parental ability to change, 60% considered sustainability and 70% of assessments considered motivation.
- 55% of assessments explored all three of the above elements of change.
- 45% were good or outstanding.

These findings indicate that there has been significant improvement in social workers understanding of change theory and their use of this in assessment; this can be used to support more timely and effective planning for children.

The audit on assessments which resulted in no further action found that over two-thirds of the assessments were good quality, and a number of good practice examples were identified. The majority of assessments (82%) reflected the child's voice and lived experience and there were again a number of good practice examples of direct work with children in which the child's lived experience was clearly explored and recorded.

The children's social care audits in Q1 found that 34% combined assessments were good or better, and 37% of cared for assessments. This is a significantly improved picture from the time of the inspection. Assessments are regularly updated within timescales and this is monitored through Performance Challenge sessions.

A Child Risk and Needs Assessment on domestic abuse was developed jointly by the Specialist Domestic Abuse Sector and Children's Services and promoted through Practice and Performance Workshops, Safeguarding Children from Domestic Abuse Training provided by the LSCB and through Children's Services Managers Meeting. It forms part of the suite of tools presented in Toxic Trio training which covers the impact of domestic abuse, substance misuse and mental ill health and is also provided through the LSCB. This course has been extremely highly rated by the workforce for its quality. This is supporting understanding of the impact of these issues on children and young people. A multi-agency audit on domestic abuse in November 2016 showed that the risks from domestic abuse are appropriately and swiftly identified and responded to, and that risk assessment tools are consistently used to assess the level of risk.

The Council employs the Independent Domestic Violence Advocacy (IDVA) team who now have access to the Children's database, Liquid Logic, to improve partnership work to safeguard children. IDVAs and commissioned domestic abuse services are also co-located 3 days per week with each CiN/CIP team and attend all Initial Child Protection Conferences where domestic abuse is a factor in order to improve multi-agency safeguarding responses. Independent Reviewing Officers and specialist domestic abuse staff confirm these measures are improving planning and decision making for children and their families.

The IDVA team also leads on a 24/7 access point for domestic abuse services sited alongside Cheshire East Consultation Service and the Police Public Protection Unit ensuring that key information regarding risks to children from domestic abuse are shared at the earliest point in assessment. There are plans to enhance this work through fast tracking the Multi-Agency Risk Assessment Conference (MARAC) process which will review incoming cases on a daily basis.

Awareness raising around connected persons arrangements has been carried out and there is now a much greater understanding of this throughout the workforce; Reg. 24 assessments are being completed when appropriate. The Service Manager has oversight of assessments. Work is underway to improve our processes and support around family and friends arrangements as outlined in recommendation 8. A Family and Friends Court Work Task and Finish Group has been established, which is working on:

- Polices and procedures in need of review or development
- Ensuring templates are compliant with good practice
- Special Guardianship Support Plans
- Improving Practice through key liaison meetings and joint working across CIN/CP, Fostering and Legal Services.
- Improving Quality Assurance through the development of a crib sheet for Team Managers so expectations are clear and managers have the knowledge and understanding of good practice when signing off specialist assessments, such as Parenting Assessments, Sibling Assessments and Connected Person's Assessments.

The contact policy is currently being reviewed. We have reviewed how contact is supported and this is now a much more robust and managed process.

Areas for improvement

Despite significant progress achieved, the majority of our assessments still require improvement. Adopting Signs of Safety will support continued improvements to the quality of our practice.

Assessments of connected persons still need to be improved to ensure they are robust. Timeliness of submission of Reg. 24 assessments to panel still needs improvement.

An audit on pre-birth assessments in July 2017 showed that inclusion of the birth father and the extended family in the assessment and planning is an area which we need to improve.

Next Steps

Adopting Signs of Safety will support continued improvements to the quality of our assessments and practice. Work is currently underway aligning Liquidlogic with the approach. Good practice examples of assessments using Signs of Safety will be developed to support good practice.

The process for the completion of Viability Assessments will be reviewed alongside expectations around joint working between fostering and CIN/CP, and good practice guidance on the completion of viability assessments will be shared at the Service Managers meetings.

The contact policy is currently being reviewed.

Evaluation

Significant progress has been made, but as the majority of practice is not yet good, this recommendation has not been met.

Assessments are now timely and regularly updated. The quality of assessments has significantly improved, although the majority do still require improvement. As a core element of social work practice, improving the quality of assessments is a consistent focus of all children's social care services, and therefore will be continued and maintained effectively through service development activity and support through audit. Progress will continue to be monitored by Children's Services, the LSCB and other partnership boards through audit. A body of work is in place to drive improvements to assessments of connected persons and family and friends arrangements.

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 (paragraphs 31, 32, 34, 36, 52, 55, 57, 65, 115).

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.

Strengths

The quality of plans has significantly improved. Plans are current, individualised, child centred and increasingly SMART. In the last audit in Q1:

- 56% CIN Plans were good or better
- 50% CP Plans were good or better
- 65% Cared for Children's Plans were good or better
- 94% evidenced that the social worker had appropriately identified and challenged the safeguarding concerns
- 96% evidenced that the social worker took the right action at the right time to protect the child and their siblings
- 87% evidenced that intervention had improved outcomes for the child/ young person

This is a significant improvement since the inspection. As outlined under recommendation 8, a considerable body of work has taken place to support assessment of parental capacity to change which has resulted in increased understanding of sustainability.

A recent themed audit was undertaken in June 2017 by the CiN/CP Service to quality assure decision making around cases where children had been on a Child in Need Plan for more than six months. Some of the findings included:

- 65% of cases were judged to be good or better

- There were a number of examples where the social worker had made an additional effort in ensuring that birth fathers were included in the plan.
- There was evidence of social workers building positive and meaningful relationships with the children and young people they were working with.

A reflective session also took place with Team Managers to consider the learning from the audit and a proposed action plan has been developed to address the objectives and areas for improvement identified.

A pre-birth audit has recently been completed which showed the contribution of partner agencies in planning and assessment was evident in nearly 90% of cases.

Increased scrutiny has been put in place to drive improved outcomes for children who are at risk of drift and delay. All children who have been on Child Protection Plans for over 9 months, are subject to repeat CP planning, or have been involved in the pre-proceedings process for over 6 months are reviewed by a Service Manager or Head of Service on a monthly basis.

The core training offer for Social Workers and Managers supports 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.

Child Protection IROs have developed strategies to better prepare children, young people and parents for initial and review conferences and increase their understanding of the child protection process prior to their first conference. Conference processes have been changed to make them more 'child accessible' and we are co-producing a video with children and young people to explain the conference process. IROs ensure that there are clear contingency plans in place when cases are stepped down from Child Protection to ensure that the right action is taken immediately if outcomes for the child or young person start to deteriorate.

Good quality Pathway Plans have been developed and embedded to ensure the best outcomes for care leavers. Regular team audits and team learning events take place to share learning and good practice.

Cheshire East is now part of a Regional Adoption Agency called 'Adoption Counts'; we are working to ensure that this move realises best outcomes for our children in care by effective and prompt planning for adoption including best practice for concurrency planning and foster to adopt.

In the last PEP audit in summer 2017, over 70% PEPs were good quality. The summer network event for Designated Teachers focussed on making sure that teachers understood their responsibilities regarding cared for children and how the Virtual School can assist in these. There was a focus on the quality of target setting within personal education plans (PEPs) and the group produced a revised framework for assessing the level of support needed and the rating of the PEP quality. Schools have also been supported with bespoke training and this has taken place in more than ten schools or colleges with individual teachers or groups of staff who support particular children.

Areas for improvement

A recent audit regarding children who had been on Child in Need Plans over six months found there are some improvements needed with regards to evidencing the child's lived experience and contingency planning. Despite the significant improvements achieved, plans still need to be SMARTer and more outcome focused.

Next Steps

We will adopt Signs of Safety as our way of working across Children's Services, which will support a continual questioning approach to explore and understand the strengths and risks within families. The approach includes capturing the child or young person's thoughts, worries and wishes, and this underpins and drives all the work with the family. A core aspect of the Signs of Safety approach is identifying the timescale for when change should be achieved for every plan, which makes plans more timely. The risk for the child or young person is scored at every planning meeting which requires that all professionals and the family reflect on the progress achieved so far.

Letters before proceedings and the contract of expectations are being revised in line with Signs of Safety so they are clear for parents.

Evaluation

Significant progress has been made, but as the majority of practice is not yet good, this recommendation has not been met.

The quality of plans has significantly improved, and for the most part the majority of these are now good or better. As a core element of social work practice, improving the quality of plans is a consistent focus of all children's social care services, and therefore will be continued and maintained effectively through service development activity and support through audit. Progress will continue to be monitored by Children's Services, the LSCB and other partnership boards through audit.

10	Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded (paragraph 39).

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.

Strengths

Children are continuing to receive the right service to meet their needs; the Q1 audit showed that step up and step down is appropriate for the vast majority of cases (95%). Performance has been consistently high on this measure. The July 2017 prevention audit also found that step up and step down decisions were taken appropriately.

A deep dive analysis of assessments that resulted in no further action (NFA) showed that:

- In most cases (87%) auditors found that it was the right decision for the assessment to conclude as NFA and for it to then close or step down to CAF.
- A rationale to support decision making was found in 93% cases.

There is a clear process in place for when cases are stepped down, with Child in Need Team Managers chairing final Child in Need meetings and Step Down meetings so that they have oversight of the case and ensure the arrangements around step down are robust.

The percentage of children and young people subject to a CP plan for a second or subsequent time and the percentage of repeat referrals remain low which indicates that intervention is effective.

Areas for improvement

In the audit of assessments resulting in NFA, step down to CAF did not always appear to be actively considered and, of the cases that did not step down, 25.5% would have benefited from CAF support to offer co-ordination of services and to monitor and measure effectiveness of interventions.

A deep dive audit of re-referrals showed that 55% of cases sampled which were re-referred did not have a CAF in place on step down which potentially could have prevented re-referral.

Ensuring the change achieved is sustainable is a key focus for the service. Signs of Safety will support developments to practice in this area through the development of Safety Networks and coproduction of plans with families.

Next Steps

The step down process is being reviewed and revised and will be relaunched across teams. Signs of Safety will support robust step down arrangements through the involvement of family networks throughout planning. The family network continue to support the family once services withdraw.

A work plan for the LSCB Early Help Sub Group has been developed and implemented to drive developments across the partnership and ensure we support families at the earliest possible stage. The work on the group has included the development of a new Early Help

Strategy. The levels of need are currently being refreshed and are out for consultation with partners. These will be discussed in detail at the LSCB in September 2017.

We will continue to improve reporting around step down and CAF take up in order to drive effective challenge within the LSCB on partnership working. An Early Help Performance Management Framework is to be established. Within the redesign of the front door, we have increased the support available to partners undertaking CAF to ensure that partners are supported to develop the confidence and skills to lead high quality work with families. This is a significant additional resource. The CAF training programme will be relaunched to support partners to lead and contribute to high quality CAFs. The CAF multi-agency audit programme has just been relaunched.

A review of Early Help services is underway to ensure that we meet the needs of our children and young people early and prevent escalation. Signs of Safety will be adopted across early help services to ensure we have a consistent approach for working with families.

Evaluation

This recommendation has been met.

Step down is happening at the appropriate time for children and young people, and the rationale for management decision making is evident, therefore this recommendation has been met. When this is within CIN/CP, the process is robust. The next step is strengthening step down to CAF to support families to sustain change. This is a key focus for the service; the step down process is being reviewed and revised and will be relaunched across teams and Signs of Safety will support robust step down arrangements through the involvement of family networks throughout planning.

Recommendations we agreed were met in July 2016

Quality of Practice

11	Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays (paragraph 78).

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 had to complete too many forms for decisions foster carers could make.

Strengths

The Foster Carers' Handbook was 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 is available 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. The Foster Carers' Annual Survey in 2016 showed that the vast majority of foster carers are aware of delegated authority and feel they are supported to make reasonable and appropriate decisions through this process

The forms on the child's record system were improved to support practice. This included a new Care Plan document which puts delegated authority in a clearer format, this has further strengthened practice in this area; young people's aspirations and financial entitlements are being captured and we are seeing improved outcomes.

Evaluation

This recommendation remains met.

Clear guidance on the policy has been developed, which has resulted in clarity for social workers and foster carers. The forms have been revised and streamlined.

12	Improve the timeliness of initial health assessments so that children who become looked after have their health needs assessed within the expected timescales (paragraph 67).

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.

Strengths

Marked improvement has been achieved and sustained over the past year to the timeliness of initial health assessments requested within 48 hours of the child or young person coming into care, from 16% in Q1 2015-16 to 78% this quarter (Q1 2017-18).

A root cause analysis has been undertaken during this time by both Clinical Commissioning Groups and as a result:

- dedicated IHA clinics have been established in both South and Eastern CCG's,
- the pathways for initial health assessments and escalation have been updated.
- the Designated Doctor has provided bespoke training for paediatricians undertaking initial health assessments including raising awareness regarding assessing the risk of child sexual exploitation.

Timeliness of initial health assessments has been closely monitored by the LSCB Quality and Outcomes Sub Group and Corporate Parenting Operational Group.

Areas for Improvement

The percentage of initial health assessments being completed by paediatricians within 20 days has remained at a low level.

Capacity issues within paediatric clinics accounted for 6 of the children not being seen within time frame in Q1. The recent employment of another community paediatric consultant is expected to ease this pressure going forward.

The remaining children were late having their initial health assessments for a variety of reasons. These included late notification of placement by the Local Authority, cancellation of appointments by foster carer, child not brought to appointment, placement changes for children, abscondment from placement, and clash of health appointment with Cared for review meeting. These issues highlight the need for continued close working between health professionals, social workers and foster carers to meet cared for children's health needs in a timely fashion.

Next Steps

East Cheshire Trust are exploring the possibility of a more flexible approach to where IHAs take place, rather than the expectation that all children will attend a clinic at the hospital.

Similarly, Mid Cheshire Hospital Trust are exploring alternative locations including community clinics based in the South of Cheshire East.

A draft pathway for the completion of Goodman's strengths and difficulties questionnaire as part of the initial health assessment is being developed in order to improve baseline mental health assessment.

Evaluation

This recommendation is not met.

In July 2016, performance information was showing a positive trajectory for both elements of the process, so this recommendation was agreed as met, as performance would be closely monitored to ensure this increase in timeliness continued. However, the timeliness of the completion of initial health assessments still requires significant improvement, despite the majority of requests now being made within 48 hours. Work continues to be underway within health and social care to improve processes around this. Close scrutiny arrangements are in place through the LSCB Quality and Outcomes Group and the Corporate Parenting Committee and Operational Group.

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 (paragraph 107).

Background to the recommendation

Later in life letters were variable in quality.

Strengths

Later-in-life letters are produced by the Social Workers within the Permanence and Through Care Team who are working with the children concerned, with quality assurance advice provided by Adoption Counts Social Workers. The Service Manager for Permanence and Through Care and the Service Manager who links with Adoption Counts dip sample letters to ensure quality. A tracker is in place to monitor and ensure the timely production of later in life letters. All later-in-life letters are quality assured by Team Managers, and this is overseen by the Service Manager for Adoption. 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.

A good quality standard has been established and letters are being produced to a good standard. Team Managers continue to monitor the quality of the letters and track timely production.

Evaluation

This recommendation remains met.

Later-in-life letters continue to be produced to a good standard and processes are in place to quality assure these and support consistency.

Listening to Children and Young People

15	Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice (paragraph 142).

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.

Strengths

A learning action plan has been developed to address the themes from complaints and is presented and agreed at Service Managers' meetings. This is also regularly taken to the Children's Social Care Leadership Team meetings for scrutiny. Progress against this is tracked and monitored to ensure effective action is taken.

The number of complaints received from children and young people and parents this year remains consistent with performance in 2015/16; nine complaints were received in both years from children and young people, or from an advocate on their behalf, and this year 92 complaints were received from parents, compared with 89 last year. **A total of 42 compliments were received this year**.

Compared to the number of referrals received and assessments completed (3438 and 4113 respectively) complaints represented only 3.5% of referrals received, and over 50% of those complaints were either 'Not Upheld' or 'Not Pursued/Withdrawn'. Although themes such as communication and delays continue, a decrease has been noted in the number of complaints mentioning these issues, and the service continues to improve in managing complaints at the local level despite continuing pressures.

The vast majority of complaints (over 90%) continue to be resolved at Stage 1 of the complaints process, and of those resolved over 40% are 'Not Upheld'.

No complaints received since 1 October 2016 have been escalated to Stage 2 so far, which is positive. Only two complaints received in 2016/2017 have been escalated to Stage 2, along with a further 2 received prior to 1 April 2016. The percentage of complaints escalated has decreased this year with only 2% escalated to Stage 2 in 2016/17 compared with 6% in 2015/16.

Themes from compliments and complaints to children's social care services 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 and the Practice Champions Group. Good practice is 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.

A report on complaints, compliments and comments, FOIs, data protection, MP Letters and education complaints is presented to the Children's Services Directorate Management Team to ensure they have oversight of all feedback and requests for information and can identify

and address any themes. The learning from complaints is also considered in the audit reports to identify if there are any shared issues or learning.

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 and child protection feedback survey, which is completed at the last core group meeting as cases are closed to children's social care. The results of this survey show that families feel supported and listened to by their social workers;

- 100% said their Social Worker was easy to talk to
- 96% felt their Social Worker understood their situation
- 96% said that their Social Worker listened to their views
- 93% felt their Social Worker was reliable and did what they said they would do

Evaluation:

This recommendation remains met.

Analysis of complaints is resulting in action to improve practice, the number of complaints is low in relation to the volume of work, and compliments are also received on the service.

Management Oversight

1	Strengthen senior managers' oversight and monitoring of: a) complex cases where there are historic drift and delay in taking decisive action (paragraph 36) b) private fostering and connected persons' arrangements to ensure that these arrangements are suitable and comply with regulations (paragraphs 40, 83) c) care leavers who are homeless (paragraph 112).

a) Complex cases

Background to the recommendation

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.

Strengths

Robust processes are in place to ensure there is effective management oversight at all levels across the service and drift and delay is addressed and prevented. This includes:

- **Critical case reports** which are sent to the Director of Children's Services to ensure senior leaders have oversight of high risk cases.
- **Performance Challenge Sessions,** which have been reviewed to ensure they focus on the **quality** of our services, and the **impact on the child or young person**, rather than compliance. Performance Challenge Sessions are held for every service and include individual performance data for workers. The Service Manager challenges Team Managers on their team's performance, and separate Challenge Sessions are held between Heads of Service and Service Managers, were they are held to account for their service's performance.
- **Performance reports and a tracker for court work** which monitors the timeliness for pre-proceedings and Legal Advice Meetings. These are scrutinised monthly at legal liaison meetings. Cared for IROs actively track the progress of children where there is a court timetable and escalate where there is any delay so this can be addressed swiftly.
- The **Permanence Tracker** continues to support the timeliness of placement planning.
- **Increased scrutiny has been put in place to drive improved outcomes for children who are at risk of drift and delay**. All children who have been on Child Protection Plans for over 9 months, are subject to repeat CP planning, or have been involved in the pre-proceedings process for over 6 months are reviewed by a Service Manager or Head of Service on a monthly basis.

Work is underway to ensure we take timely action for our children and young people. A workshop on improving our processes around Public Law Proceedings has been held focusing on making our action more timely for children and young people, and an action

plan has been established, which is being delivered by task and finish groups. More detail on this is covered under recommendation 6.

Next Steps

Joint safeguarding and CiN/CP Performance Challenge meetings are to commence to ensure there is joint ownership and accountability for outcomes for children and young people, and to develop strong working relationships and increased understanding between teams.

Evaluation

This element of the recommendation remains met.

Robust monitoring arrangements are in place, which are supporting effective management oversight from senior management level to team managers. Performance is scrutinised regularly and in detail down to individual level. A considerable body of work is taking place to improve the timeliness around the court process to prevent children and young people experiencing drift and delay.

b) Private Fostering and Connected Persons Arrangements

Background to the recommendation

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 Service Managers.

Strengths

Significant improvements have been achieved in respect of frontline responses to new private fostering arrangements. Potential arrangements are being recognised quickly and appropriately responded to, and children and young people are being seen within seven days as per statutory guidance. Management oversight is in place; regular meetings are held between the Head of Service for CIN/CP and the lead IRO for private fostering which focus on achieving permanency for children and young people, reviewing progress and timeliness of assessments. A performance report is produced monthly on privately fostered children and young people to enable monitoring and scrutiny. Assessments are being completed in a timely manner.

At the time of the inspection, there were just three privately fostered young people known to the authority. As a result of awareness raising activity across the partnership, this number has considerably increased. In 2016/17 we were notified of 10 new private fostering arrangements.

The Private Fostering Policy and Procedure has been updated to ensure the process and expectations on timescales are clear. The process within the child's record system for private fostering has also been streamlined to ensure the system supports efficient and timely practice. Timescales for Privately Fostered children and young people are also monitored through Performance Challenge Sessions.

The Children's Safeguarding and Quality Assurance Unit (SQAU) also offers independent oversight of the private fostering arrangement; they are notified each month of any new notifications and data is cross-referenced to ensure the correct pathway has been followed and to enable the early monitoring of cases. Each privately fostered child or young person has an allocated Child Protection IRO who will arrange a combined CIN/private fostering review to ensure there is independent oversight of the plan.

Awareness raising around connected persons arrangements has been carried out and there is now a much greater understanding of this throughout the workforce; Reg. 24 assessments are being completed when appropriate. The Service Manager has oversight of assessments and there is a tracker in place to support effective scrutiny and oversight. Work is underway to improve our processes and support around family and friends arrangements as outlined in recommendation 8.

Areas for improvement

Timescales in relation to the DBS process still require some improvement as there is at times delay caused by carers not providing required information/identification promptly. Strategies are currently being identified to address this as part of service development work for 2017/18.

Next Steps

Strategies will be developed to improve the timeliness of DBS checks.

The work of the Family and Friends Court Work Task and Finish Group will strengthen processes and support for connected persons arrangements.

Evaluation

This recommendation remains met.

Management oversight is in place for private fostering and connected persons arrangements. Significant improvements have been achieved in respect of frontline responses to new private fostering arrangements and these cases are effectively overseen by managers through the Performance Challenge Sessions. The timeliness of DBS checks still requires some improvement which is being addressed through the development of internal action plans. The work of the Family and Friends Court Work Task and Finish Group will strengthen processes and support for connected persons arrangements.

c) Care leavers who are homeless

Background to the recommendation

Service Manager's oversight of care leavers who are homeless needed to be strengthened. At the time of the inspection six 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.

Strengths

There are robust arrangements in place to ensure that there is effective oversight of care leavers in unsuitable accommodation or who are homeless, which includes:

- Monthly **permanence case tracking meetings**, chaired by the Head of Service, take place to ensure there is clear senior management oversight and drive for permanence.
- A **tracker for care leavers who are homeless** which is used to effectively track and monitor these young people, and this is overseen by the Service Manager on a monthly basis. Data on unsuitable accommodation is also monitored and tracked, and there is a detailed spreadsheet to track all 'eligible' care leavers and their transition plans, contingency plans and next steps. These Care Leavers are tracked and monitored via the Ignition Panel and monthly challenge meetings.
- **The Corporate Parenting Committee and Corporate Parenting Operational Group provide oversight in this area and a scorecard is regularly updated and scrutinised**. The scorecard is produced quarterly and on an annual basis the Corporate Parenting Committee looks in more depth at outcomes for care leavers, including their accommodation.

Areas for improvement

Data sharing between housing and children's social care needs to be strengthened. This will be improved through the Corporate Parenting Strategy.

Next Steps

The Corporate Parenting Committee will be undertaking specific deep dive analysis of particular themes to scrutinise and drive improvement and the development of the new Corporate Parenting Strategy.

Evaluation

This element of the recommendation has been met.

There are robust arrangements in place to ensure that there is effective oversight of care leavers in unsuitable accommodation, or who are homeless.

13	Ensure audit arrangements have a sharper focus on looked after children (paragraph 140).

Background to the recommendation

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.

Strengths

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. Audits are completed and reported on a quarterly basis to the Children's Social Care Leadership Team and the Children and Families Directorate Management Team. Audits are reported to the LSCB to ensure partnership scrutiny. The findings are communicated to the whole children's services workforce through the audit newsletter.

The audit process has been redesigned to focus on the quality of the outcomes achieved for the child or young person rather than compliance; this has driven improvement and enabled the workforce to recognise and embed good practice. Audit has now been aligned with Signs of Safety. Detail on the performance from audits, including performance on the Permanence and Through Care Team, is included within the comprehensive audit scorecard.

Regular themed Pathway Plan Audits for young people aged 16+ are undertaken by the Service Manager for Permanence and Through Care and there are improvements evident in the quality of practice. Audits have so far taken place on the following themes:

- Emotional Well-being and Mental Health
- Substance Misuse
- 16/17 year olds in semi-supported accommodation

Next Steps

The Care Leavers Service will be completing a Peer Audit of Pathway Plans in September 2017.

Evaluation

This recommendation remains met.

The quality of our cared for services is effectively scrutinised through audits and this is reported through the appropriate routes to ensure senior managers, service and team managers, staff and partners are aware of how our cared for service is performing and the areas for improvement.

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 information provided through the electronic recording system so that managers have effective oversight of frontline practice (paragraph 137, 138).

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.

Prior to the inspection, the electronic recording system for Children's Social Care (Paris) was replaced with a modern case management system (Liquidlogic) 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.

Strengths

A scorecard for children's services is received on a quarterly basis by Children and Families Scrutiny Committee to ensure they have oversight and can scrutinise and challenge performance in children's services.

A range of reporting suites are available on children in need and child protection, cared for children and care leavers. 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.

Performance Challenge data is produced and sent to managers on a fortnightly basis to supplement readily available reports. All performance, including individual performance is scrutinised through the performance challenge sessions. The Performance Challenge sessions have substantially improved the timeliness and accuracy of data loaded into the system. 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.

Liquid Logic was launched almost three years ago, and the quality of data due to migration is no longer an issue as it was at the time of the inspection. Issues with migration of data from the old case management system to our current system are now resolved and data reporting is reliable.

Evaluation

This recommendation remains met.

Effective performance monitoring arrangements are in place and are driving improvements to practice.

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: (paragraph 150) • 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 (paragraph 114) • ensuring sufficient health provision for older looked after children and care leavers (paragraphs 121, 124) • improving the use of family group conferences so that all possible options for children are consistently explored (paragraph 55) • increasing the capacity of advocacy services to support children and young people identified as in need (paragraphs 45, 85, 150).

Background to the recommendation

There was no joint commissioning strategy in place.

Foyer accommodation was used as a last resort for young people who were 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.

Strengths

A joint commissioning strategy is in place which was endorsed by the Children and Young People's Trust and the Health and Wellbeing Board.

A robust risk assessment tool in place for use with YMCA / foyer accommodation. Every young person in semi-supported accommodation (e.g. Watermill House, MoCoCo House, the YMCA) is risk assessed as per the recommendation. A dedicated support worker for 16-17 year olds will be put in place within Crewe YMCA.

We now have improved knowledge of our data, better oversight and understanding of our service and a 16/17 year old tracker to support planning on next steps accommodation options for young people. Data tracking is in place for young people in staying put arrangements, semi-independent provisions and forum housing. The trackers are reviewed in monthly Performance Challenge sessions.

We have improved our 16+ options with ring fenced properties. We have a tenancy readiness programme which offers care leavers the opportunity to think about the merits of having their own property and the responsibilities that may come with this. Four programmes were set up over 2016 and 13 young people engaged in this work over a 4-6 week period, with 4-6 care leavers participating at any one time. Seven of these have successfully moved to independent living, two have moved into supported lodgings, three have taken part in a trial at a taster flat and one has a moving on plan for semi independence from residential care in the coming months.

The 'Ignition panel' has been established which is an innovative project to support young people to have the best, most appropriate transition for when they leave care. Ignition is for young people aged 15½ plus who are thinking about where and how they would like to live when they leave care. Making sure our young people start independence at the right time and in the right place provides the best chance for a positive journey to adulthood and will support the best possible life chances. The panel shares ideas, suggestions, and good practice to develop an action plan that will support each young person to achieve their future living goals. This may be accessing a taster house, supported lodging or being supported through a semi-independent setting with a phased transition to young people being in their own property. The Ignition panel has been shortlisted for the Children and Young People Now Awards in 2017.

The post for the 16+ and Transition Cared for Young People's Nurse has been filled for over a year.

The take up of advocacy and independent visiting services was reviewed and target priorities have been set through negotiation with commissioned provider, The Children's Society. The advocacy service has been amended to be available for children with complex needs e.g. children with a disability. Automatic referral has been introduced to advocacy for children and young people at child protection. Young people have developed a short animation for young people to explain the role of an advocate and an independent visitor which is used to promote the service to children and young people.

Over the past year, IROs and The Children's Society have been working closely together in ensuring that young people are being offered an advocate to not only represent their views but to robustly challenge on the young person's behalf as well, further ensuring that their wishes and feelings were incorporated within the work that IROs and social workers undertook. Awareness raising with staff continues through attendance by The Children's Society at Practice and Performance Workshops and Team Meetings. The Head of Service for Safeguarding Children and Families has led a review of current advocacy provision, and following this there are changes planned for the way we deliver advocacy in the future which ensures this is also part of all frontline workers' roles with children and young people.

The use of Family Group conferencing has been reviewed and we are now using the Connected Persons model instead, which involves our Fostering Teams.

Areas for Improvement

We need to improve our practice with regards to Connected Persons Meetings and the procedures around this are being reviewed at present.

Evaluation

This recommendation remains met, and whilst we have decided not to implement a traditional Family Group Conferences model we will continue to strengthen core social work practice by using Connected Person's meetings.

All young people in foyer or hostel accommodation have a risk assessment in place. Young people who are in unsuitable accommodation or are homeless are closely monitored by the Service Manager. Health support for cared for children and care leavers is in place. Automatic referral to independent advocacy for children and young people at child protection is in place.

We need to improve our practice with regards to Connected Persons Meetings and the procedures around this are being reviewed at present.

Appendix:

Monitoring arrangements for recommendations that have not yet been met

Recommendation	Monitored through	Supported by	Planned Actions
Rec. 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. ***Will be met once timeliness is restored***	• Performance Challenge Sessions	• ChECS Performance Dashboard	Staff are being recruited to the new posts to meet the additional demands in the new structure. We will continue to closely monitor the timeliness of decision making at Early Help Brokerage to ensure this returns to the previously high levels. A review of Early Help services is underway to ensure that we meet the needs of our children and young people early and prevent escalation. Signs of Safety will be adopted across early help services to ensure we have a consistent approach for working with families.
	• Children and Families DMT	• Prevention Scorecard	
Rec. 5: Ensure that strategy meetings and decisions are informed by relevant partner agencies	• LSCB Safeguarding Children Operational Group • LSCB Quality and Outcomes Group	• IRO thematic audit	A repeat IRO audit on Strategy Discussions will take place in October 2017. Regular Police Liaison meetings take place and Strategy Discussions are to be a standing agenda item. We are currently reviewing the process for Strategy Discussions that take place shortly after referral to see if this could take place in the front door with the involvement of the integrated multi-agency team. A task and finish group is currently reviewing how lack of invitation or attendance can be challenged by partners, and whether themes and trends can be collated and reported to the LSCB Executive. Work is also being undertaken to support better use of video conferencing across the partnership to enable all partners to participate.
Rec. 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	• LSCB Board and sub groups • Corporate Parenting Board and Operational Group • Children and Families	• CSC Audit reports • IRO Thematic Audits • LSCB Multi-agency Audits • Children and Families Scorecard • LSCB Scorecard	Adopting Signs of Safety will support continued improvements to the quality of our assessments and practice. Work is currently underway aligning Liquidlogic with the approach. Good practice examples of assessments using Signs of Safety will be developed to support good practice.

reflect changes in circumstances.	DMT • Children and Families Overview and Scrutiny Committee		The process for the completion of Viability Assessments will be reviewed alongside expectations around joint working between fostering and CIN/CP, and good practice guidance on the completion of viability assessments will be shared at the Service Managers meetings. The contact policy is currently being reviewed.
Rec. 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.	• LSCB Board and sub groups • Corporate Parenting Board and Operational Group • Children and Families DMT • Children and Families Overview and Scrutiny Committee	• CSC Audit reports • IRO Thematic Audits • LSCB Multi-agency Audits • Children and Families Scorecard • LSCB Scorecard	We will adopt Signs of Safety as our way of working across Children's Services, which will support a continual questioning approach to explore and understand the strengths and risks within families. The approach includes capturing the child or young person's thoughts, worries and wishes, and this underpins and drives all the work with the family. A core aspect of the Signs of Safety approach is identifying the timescale for when change should be achieved for every plan, which makes plans more timely. The risk for the child or young person is scored at every planning meeting which requires that all professionals and the family reflect on the progress achieved so far. Letters before proceedings and the contract of expectations are being revised in line with Signs of Safety so they are clear for parents.
Rec. 12: Improve the timeliness of initial health assessments so that children who become looked after have their health needs assessed within the expected timescales.	• LSCB Quality and Outcomes Sub Group • Corporate Parenting Board and Operational Group • Children and Families Overview and Scrutiny Committee	• Corporate Parenting Scorecard • Children and Families Scorecard • LSCB Scorecard • Reports on IHAs	East Cheshire Trust are exploring the possibility of a more flexible approach to where IHAs take place, rather than the expectation that all children will attend a clinic at the hospital. Similarly, Mid Cheshire Hospital Trust are exploring alternative locations including community clinics based in the South of Cheshire East. A draft pathway for the completion of Goodman's strengths and difficulties questionnaire as part of the initial health assessment is being developed in order to improve baseline mental health assessment.

Rec. 7: Strengthen frontline practice to ensure effective action is taken to support children who go missing	• LSCB CSE, Missing from home and care and child trafficking Sub Group	• Missing from Home and Care Audits • Missing from Home and Care and CSE Reports • Missing from home and care Tracker	The CSE and MFH team will deliver workshops around analysis of risk, developing SMART plans and the MFH Protocol for Social Workers to support completion of high quality return interviews and ensure that information from these interviews informs planning. The CSE and MFH team will inform Team Managers of Service Declines at regular intervals and for those in care this will also be sent to the Safeguarding Unit for additional IRO oversight to support improvements to practice. Activity to support improvements to the quality of assessment and planning are outlined under recommendations 8 and 9.
	• LSCB Board	• LSCB Scorecard • Missing from home and care annual report • Sub Group reports	
Rec. 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 improving the use of family group conferences so that all possible options for children are consistently explored	• Children and Families DMT	• Service reports	Whilst we have decided not to implement a traditional Family Group Conferences model we will continue to strengthen core social work practice by using Connected Person's meetings.