Barbara Trevanion
Chair, Bexley Local Safeguarding Children Board
c/o London Borough of Bexley
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13 March 2015

Dear Barbara

**BEXLEY LOCAL SAFEGUARDING CHILDREN BOARD DIAGNOSTIC**

On behalf of the team I would like to thank the Bexley Local Safeguarding Children Board (BSCB), the council and partner agencies for commissioning the recent LSCB diagnostic pilot (phase two). We undertook this work on 24 – 26 February 2015.

It is important to emphasise that this was not an inspection but a critical friend diagnostic delivered by a team of peers. The aim was to provide an informed, external perspective on the quality of the LSCB, its key strengths and areas for improvement.

The Diagnostic team was asked to answer four questions and to provide feedback on progress made against OFSTED recommendations of May 2014. This letter will consider these first before giving feedback in relation to the LSCB diagnostic.

## Question One: Is the Board discharging its statutory functions effectively?

The Peer team was asked to assess whether the BSCB was compliant with statutory functions as set out in the 2006 LSCB regulations and the requirements of Working Together 2013. The team observed the following:

Policies and procedures for safeguarding are in place in Bexley.

Arrangements for monitoring and evaluating the effectiveness of practice across the partnership are in place although the collation and analysis of data requires further development. .

Communication among partners on the board is effective. The Chair has their support and there is a visible profile of the BSCB through the website and training programme.

The BSCB Chair is a full member of the Health and Wellbeing Board and is able to influence plans and decisions about local services.

A clear pathway and process is in place to consider potential serious case reviews. Arrangements to monitor the implementation of action plans have been improved.

The BSCB has not been able to assess the effectiveness of the Early Help offer. This is down to the quality of the reporting to the board rather than the efficacy of the BSCB itself. Effort has clearly been made by the Chair to address this matter.

The BSCB has assessed the effectiveness of partner agencies to discharge their statutory responsibilities to safeguard and promote the welfare of children through Section11 audits. There was clear evidence of challenge by the chair and acceptance of the need to improve by partner agencies. Consequently, this is a strong area of performance.

The quality assurance of frontline practice has been initiated with an audit programme, addressing early help, child protection conferences, family violence and thresholds for help, protection and care. This requirement is therefore met, though as the process is repeated, an increased focus on the difference that practice is making for children and their families is required.

The BSCB is clear about its responsibility to identify service improvements and examples of effective challenges were provided.

The membership of the BSCB is comprehensive with the exception of a second Lay Member which is a legislative rather than a regulatory requirement.

The Child Death Overview Panel (CDOP) arrangements meet the legislative requirements and there are plans to strengthen further in respect of cross boundary co-operation.

**Question Two: Is the Board now in a position to take back the lead support and challenge role for safeguarding that is occupied by the Safeguarding Improvement Board (SIB)?**

The Peer diagnostic methodology is not designed to answer this question. However, the positive evidence contained within this letter should enable senior council managers and elected members, in discussion with the Chair of the SIB to make an informed judgement about the pace and evidence of change. This includes proven capacity to:

- challenge partners and hold them to account
- drive improvement in safeguarding
- undertake effective scrutiny of safeguarding

**Question Three: Has the investment in resources sufficiently strengthened the capacity and expertise of the business support to the Board?**

We believe that the BSCB is resourced to an adequate capacity but that further improvements and efficiencies could be achieved by means of reviewing the business processes to make them more purposeful and by developing some better tools such as SMART action plans and report formats.

**Question Four: Is there evidence that the BSCB is having an impact on outcomes for children and young people in the Borough?**

This is a difficult question to answer given that we identified the area of outcome measurement as one which is not yet sufficiently developed. It is further complicated by the board not being responsible for the operational delivery of services. However, there was evidence that in respect of the requirement on LSCBs to ensure the effectiveness of what is done by partners to safeguard and promote the welfare of children and young people, the board now has the fundamentals in place to start to consider the impact of frontline practice on the lives of children and their families. .

The BSCB has also implemented an evaluation framework for training. This is designed to assess the impact of training and development on practice. Very few returns are currently received, and there is still a gap between the impact of training on professional practice and improvement of outcomes for children. Nevertheless, making the assumption that improved professional practice will have such an impact, we can say that there is likely to be a positive effect on service quality.

Several examples were provided of reports and discussion within the board which had led to challenge, and which had consequently resulted in changes to operational practice. One example was the response to missing children and young people, with a new operational approach being instigated as a result of a BSCB challenge. Whilst again no clear outcome for children and young people has yet been evidenced as a result of these changes, it has to be assumed that the strengthened capacity and focus has put in place an improved approach likely to lead to better outcomes. A second example was the provision of Vitamin D to young children arising as an action from a serious case review, designed to prevent the development of rickets in young children.

These examples show the potential for the BSCB to have an impact on outcomes by challenging and improving practice among statutory partners. Currently this progress is in its earliest stage.

## Progress against the ten OFSTED recommendations made in June 2014

### 1. Establish lead role of BSCB and set up its governance

There are comprehensive governance documents in place dealing with both the internal relationships of the BSCB and its inter-relationships with the health and well-being board as well as other strategic partnerships. This recommendation has been met.

As these arrangements embed, the board will need to lead and establish strategic priorities across the planning and delivery cycles of all partner agencies, including improved performance review.

### 2. Undertake a suitable work programme

The BSCB has a comprehensive business plan and work programme. This recommendation has been met.

As progress continues, the board must focus on those priorities that will make the most difference. The data set should be interrogated regularly to direct the work programme and to review priorities.

A risk register should also be established to support the board to focus on the areas of business that require the most urgent attention and improvement across the local safeguarding system.

### 3. BSCB to scrutinise multi-agency practice

The board has in place a developing framework through which it will scrutinise the monitoring and quality assurance of multi-agency safeguarding practice.

There is a comprehensive programme of multi-agency audits. Those that have been completed include, thresholds, the sexual exploitation of children, early help, section 47 enquiries, family violence and police referrals about children coming to notice. The recommendation is met.

The audit programme now needs to focus on the impact and difference being made to children, young people and families as a result of the help they receive. Second phase audits should be expected to identify clearer action plans associated with the initial audits and should include specific areas for further improvement across all local agencies.

**4. Audits should lead to action plans**

The BSCB audits generate action plans. This recommendation is met. However**,** all action plans (including the BSCB business plan) must establish how impact will be evaluated.

**5. Analysis of data for partner agencies, including children's social care services**

Considerable progress has been made with a multi-agency data set having been developed. The analysis of data is at an early stage and needs to develop further and more quickly. This recommendation is met in part.

**6. Ensure there are clear terms of reference for sub groups and BSCB**

There are clear written terms of reference. This recommendation is met.

**7. Audits should report on partners**

There is a well – established programme of Section 11 and Section 175 audits. These have been the subject of challenge by BSCB resulting in a requirement set by the board for further work to be undertaken. Whilst partner agencies need to strengthen their audits and action plans, the recommendation is met.

**8. Review multi-agency safeguarding training**

There is a comprehensive training plan and a series of BSCB safeguarding conferences has been recently delivered. The BSCB is increasing and improving its local profile and offering a good range of courses. There is an impact evaluation system which looks for evidence of changed practice through training. This is good practice. This recommendation is met.

**9. Introduce the voice of the child**

Steps are in place to use existing forums to consult young people about the work of the BSCB. Young people were involved in the web-site design which is good practice. As the board continues to make progress, further work should be undertaken to strengthen the engagement of children and young people. This recommendation is met.

**10. The Annual report should be an analysis of the work of the board and its partners**

The 2013/2014 Annual Report contains very little analysis of the key contextual issues of the "Bexley story", the development of the Early Help offer, or its impact on statutory work and families in Bexley. There is some statistical detail about specific areas especially Children's Social Care, but there is commentary, not an analysis.

The BSCB progress report addresses the period from the Ofsted review in March 2014 to March 2015. This report is intended as the basis for the 2014/15 Annual report and describes the activities of the board, its priorities and actions arising. The difference that board activity is making to the help, care and protection of children still needs to be clearly set out in the report.

## LSCB Diagnostic

The team comprised:

- **Christine Doorly** – LSCB Chair, Southend-on-Sea and LSCB Chair, London Borough of Lewisham
- **Liz Murphy** – Independent Consultant, formerly Safeguarding Children Business Manager Solihull LSCB
- **Ginny Roberts** – Independent Consultant, formerly Interim Performance Manager LSCB, Cheshire East
- **Ken Donnelly** – Head of Major Crime and Investigative Units, Durham Constabulary, formerly Head of Safeguarding
- **Sue Avery** – LGA Diagnostic Manager

The team interviewed key stakeholders, either individually or as part of a focus group, as well as undertaking a comprehensive review of current documentation. We were able to observe the scheduled meeting of the Safeguarding Improvement Board on 24 February 2015.

We are grateful to Lorraine Harker and her colleagues for the efforts they put into preparing for and supporting our visit and we very much appreciate the way that everybody engaged in the process. The people we met were very welcoming. We hope the council and its partners will use the peer diagnostic as an opportunity for learning, to explore possible areas for improvement and to move quickly to adopt these.

This section of the letter is designed to provide you with further detail relating to the points contained in our feedback presentation delivered on the third and final day of the diagnostic. The areas covered by this practice diagnostic are as follows:

- Board Effectiveness

- Quality Assurance and Performance Management
- Working Together Compliance
- Safeguarding Practice
- Inspection Information Health Check
- Suggestions for Improvement

## 1. Summary of progress:

This Peer Diagnostic reviewed the BSCB, particularly through the lens of progress over the last year. From a judgement of inadequate awarded by Ofsted in July 2014, the chair has led the board through a period of significant improvement and change. There is now a well-established business group, driving forward the work plan and co-ordinating the programme. The governance arrangements are clearly set out and signed off by all statutory partners. The board is now well networked, respected and it is able to be influential with both the Local Authority and partner agencies. There was clear evidence of effective challenge to the Health and Wellbeing Board, and others, through the leadership of the board Chair.

The multi-agency data set which is designed to establish how well partners are discharging their statutory responsibilities is now understood and accepted by the board as the mechanism by which it can move into the next phase of analysis and improved impact.. The board and partners understand the significance of this next phase. The culture of the board is now one that encourages open challenge and engagement. There is collective ownership of the responsibilities and priorities.

The team saw examples of the Board's improved capacity to co-ordinate tasks, for example in respect of work to protect missing children and those vulnerable to sexual exploitation. In addition there is a programme of audit work in place and these audits are beginning to be presented to the board for analysis. Further, action plans are being established on the basis of the findings, although this work is at an early stage. In addition the Section 11 audits had been completed and identified the statutory requirements of partners, with a degree of challenge from the Chair being accepted as valid. The resource base for the BSCB has been substantially and necessarily strengthened and it now has the capacity to undertake its work programme.

## 2. Summary of areas for development

The next phase of development for the board will be challenging. Partners will need to work hard to agree on the areas to prioritise. This will require pace, precision of task and relentless performance oversight of progress. The dependency on audits to identify areas for improvement will need to be supplemented by far more sophisticated measures that establish real change for children and their families. The voices and experiences of children and young people must become central to the board's regular assessment of the effectiveness of help, care and protection in Bexley.

One core area, requiring improvement is the over complex sub-group work programme. Roles and responsibilities are not set out clearly and this results in both duplication but more importantly, less focus on key priority areas than is required. Most notably, the function of the Vulnerable Children Group to oversee and direct the work of related sub groups should be more clearly set out. Equally, the Quality and Effectiveness sub group should improve its strategic oversight of qualitative and quantitative data, using this alongside comparator data and trend analysis. The main board needs to stay focused on strategic priorities whilst being supported by exception reports from the sub-groups. The completion of a rounded performance management framework would support and underpin this approach and would allow the BSCB to achieve a cycle of activity (as required by the learning and improvement framework) whereby analysis would lead to recommendations and actions and the impact of these would be evaluated. There is also a need for a risk register to support the board to focus on weaker areas of protection and care. This is understood to be in development and would benefit from being prioritised and completed.

The business plan for the board requires still further development. As has already been described above, the strategic priorities arising from the work of the sub-groups remain unclear, making it too difficult then to assess progress and impact. Without changes to the plan, the areas for the board to challenge will remain obscured. The board generally needs to become more efficient with its processes, making sure reporting formats are clear and concise, and deadlines are specific with clear escalation processes where there is slippage. It is recommended that the BSCB business plan is tightened and the high level objectives contained within it are translated into a further set of SMART objectives and outcomes for sub groups which will improve the overall sense of pace and accountability. In addition consideration could be given to introducing SMART action plans, and other ways of improving the business processes such as report formats, clear deadlines for submitting reports and an escalation process if these are not met, all of which would support the Chair in her efforts to drive the BSCB agenda forward.

The BSCB is required by regulation to evaluate the effectiveness of the early help. This was an area exemplifying where the quality of data and analysis needs to improve. Currently there is little account of what the early help offer is, what is intended and whether it is making the difference required, in particular reducing the need for more complex social care services. In addition, further attention should be given to the supporting arrangements for effective safeguarding in Bexley. The arrangements for effective scrutiny and promoting the welfare of children who are looked after require clearer prioritisation by the board. The Joint Strategic Needs Assessment (JSNA) has limited detail describing the needs of vulnerable families in Bexley. Opportunities for the board to influence the content and local commissioning are likely to be missed if the interfaces with other partnerships are not improved. Situating the BSCB and its chair within a leadership grouping tasked with taking this agenda forward would be beneficial.

## 3. Board Effectiveness

Board effectiveness - strengths

- The revised governance framework is embedded and understood by all partners. The Chair, Barbara Trevanion, is very highly regarded across the partnership and widely recognised as driving improvement before and after the Ofsted inspection.

- The board's role and function is understood by all statutory partners and there was very positive feedback from all partners on the growing strength of multi-agency relationships.

- The board is providing greater challenge to all partners, including through the Health and Wellbeing Board. Partners understand the need for this culture of challenge and express their readiness to move to the next phase beyond the existing Safeguarding Improvement Board.

- Effective arrangements are in place to engage and communicate with schools and the voluntary and community sectors (VCS). There are board representatives from schools who attend and arrangements to cascade information across the VCS as well as education sectors.

- The board business committee co-ordinates and drives business. There is clarity amongst partners in describing its role.

- Scrutiny is well placed to play an increasingly active role in assessing the effectiveness of the board. There is the capacity and willingness to develop this potential further.

- The board website is well presented, with a good structure and creative design. Young people were involved in the design of some content.

Board effectiveness - areas for consideration and improvement

- The board demonstrates much improved partnership as has already been identified earlier in this letter. Whilst some partners described the BSCB as not yet performing as a 'mature board', there is consensus that huge progress has been made and must continue.

- Greater consideration should be given to the board's impact on outcomes for children and young people and the mechanisms it can use to work through and alongside other strategic partnerships, for example the children and young people's partnership board, the (CYPB) Health and Wellbeing Board (HWBB) and the Children's Safeguarding Partnership (CSP). The Scrutiny role should be developed beyond the existing improvement board, whose responsibilities should be carefully transferred between the board and the local authority.

- Clearer board priorities should be set out with a clear delivery strategy. Many Board papers and reports refer to outcomes but they do not articulate how these are to be achieved or how the impact of activity will be assessed. The lack of outcome information is hampering the evaluation of activities undertaken.

- Engagement of schools in the protection of children and young people is described as generally good and improving, with the board instigating strong arrangements, including an active and well – attended education sub - group. This is a strong area requiring some further development, particularly around sensitive areas such as CSE.

- More attention should be given by the board to the identification and management of risk, highlighting key areas that require significant improvement across the partnership.

- The pattern of community engagement has changed as new community groups are established in Bexley and new safeguarding issues have arisen. Consideration could be given to proactive engagement with specific communities through resources such as the Independent Advisory Groups (IAG's) or the vacant Lay Member position.

- Elected Member training on safeguarding needs strengthening to ensure they are all aware of their safeguarding responsibilities, understand and can act upon the issues arising locally and nationally.

## 4. Quality Assurance and Performance Management

<u>Quality assurance and performance management - strengths</u>

- There is evidence that the board has created the foundation for quality assurance and learning. There is a learning and improvement framework and significant progress has been made in the collation of a multi-agency data-set.

- Single and multi-agency audits are completed.

- A Section 11 audit has been completed with evidence of challenge to partner agencies.

- The Safer Bexley accreditation scheme is recognised as a good initiative. Plans are in place to streamline this process so that it is applicable to smaller voluntary organisations.

- There was a 100% response rate to the Section 175 audit. This is a significant achievement showing that schools are engaged with the board locally.

- A ‘Signs of Safety’ pilot for child protection conferences is underway and has been positively received by conference chairs, parents and children.

Quality assurance and performance management – areas for consideration and improvement

- Greater evidence is needed that improvement activity is focused on outcomes for children and young people. Most outcomes stated in reports and plans relate to the completion of a process e.g. undertaking an audit. Identifying the desired change or impact at the outset of planning activity, should help to drive action and improvement, reducing the time it takes to make the changes that are required. .

- The BSCB needs to be more confident in its interrogation and evaluation of data and performance information generated by quality assurance activity. Minutes of meetings indicate that there is an over-reliance on commissioning further audits to corroborate any performance findings, and this has led to drift in some instances in decisive action being taken to address emerging issues.

- Analysis, interrogation and presentation of performance information need refining. The data-set and findings from audits and other performance information e.g. complaints, would be more meaningful if presented in a single quarterly report that analyses and evaluates effectiveness of all agencies and identifies emerging issues and trends. This report should include comparison against statistical neighbours (so board members have a sense of the expected data range for Bexley) and exception reporting by all agencies of key safeguarding performance indicators (PI’s).

- There is insufficient use of feedback from children, young people and families in the performance review framework.

- Triangulating qualitative information with the data-set would provide a rich picture of safeguarding performance and issues in Bexley, adding considerable value to the quality assurance activity being undertaken across the partnership, and enhancing the board’s efforts to use data to drive continuous improvement and to develop thematic learning.

- The learning and improvement plan primarily identifies activity progress, rather than learning. The next phase of improvement should focus on translating learning into priorities that direct the work of sub-groups.

- The learning and improvement framework would benefit from a clearly planned cycle of information, analysis, action and review.

- All reports to the Board should be purposeful e.g. highlighting improvements / issues, and evidence based.

- The documentation provided does not fully explain the assurance interface (information flow and accountability) between BSCB and other strategic multi-agency groups e.g. the HWBB.

## 5. Working Together compliance

Working Together compliance – strengths

- The board training offer has improved and a clear framework is in place for identifying the level of training required.

- The impact of board training for its own members is regularly evaluated.

- There is an enhanced case review action plan to monitor the impact of help, care and protection on children, young people and families.

- There is a clear pathway for considering cases for SCR, notification of all child deaths, review of cases below the SCR threshold but still with practice learning and there is good engagement with the national expert panel, hosted by the Department for Education.

- Local Authority Designated Officer (LADO) arrangements are embedded, with recognition of a need for further work on ‘safer recruitment’.

Working Together compliance – areas for consideration and improvement

- The board’s role in monitoring the effective delivery of early help is at an early stage and is hampered by the quality of the data and performance information being presented. It largely measures throughput, rather than the difference it is making to the lives of children and young people and their families. Where impact on outcomes is inferred, this is not quantified e.g. as a percentage of the total supported.

- The multi-agency early help offer is not clearly defined. Early Help appears to centre around the local authority Thriving Families Service. The diagnostic team found little evidence of the voluntary sector and wider partner contribution to early help, although there was felt to be potential.

- Robust analysis of the operation of thresholds locally needs to improve so that there is clarity about how to access services and professional help. Different perceptions were expressed and ‘step down’ was said to be far easier than ‘step up’.

- The annual report should be informed by the learning and improvement framework. It should include an evaluation of the effectiveness of the local safeguarding system i.e. what the Board has achieved; what still needs to be done and why / how you know; and what differences the Board aims to make to the lives of Bexley's children and young people.

- There is currently one lay member, who is enthusiastic about her role. Legislation requires two lay members and the board could use this opportunity to widen the community voice in its work.

- The partner agency response rate to evaluation of BSCB training has been patchy and there are inconsistencies in the quality assurance of single agency safeguarding training.

- A more strategic approach to training, would support the targeting of the training offer to multi-agency front-line practitioners, managers and elected members.

- The resources allocated to the board training programme have increased, with a dedicated training officer, and a budget of £10,000. This may need further revision to meet the volume of training that is required.

- Advertising/promotion of BSCB training events needs further development. A dedicated page is hosted on the Bexley learning and development web-site, but at present it is difficult to distinguish BSCB training information and the learning objectives. The target audience for the training is not always clear.

- Development of the potential of future Child Death Overview Panel (CDOP) requirements by bringing together Bexley CDOP and the cluster for better understanding of issues. A plan is in place for the CDOP chair at Bromley to act as Bexley Chair, and work is underway to move this responsibility to Bexley's Public Health service. This would then open up the possibility of negotiating cross border arrangements with Greenwich**,** which would enable a stronger overview to be achieved. Going forward, this is a positive approach.

## 6. Safeguarding practice

<u>Safeguarding practice - strengths</u>

- An effective multi–agency approach is in place for tracking and monitoring missing children and young people. The review team were impressed with the regular senior management attention given to this work.

- The rate of completed welfare return interviews has increased.

- A Vulnerable Children's Group has been established to provide a strategic response across a number of key safeguarding risks for older children e.g. missing, CSE and trafficking.

- A dedicated local police CSE team has been established.

- Bexley is planning the launch and roll out of 'Operation Make Safe' across the Borough, aimed at raising awareness of CSE amongst local businesses.

- A female genital mutilation (FGM) action plan is in place and is overseen by BSCB.

Safeguarding practice – areas for consideration and improvement

- More needs to be done to understand the prevalence and nature of CSE in Bexley. A mechanism (in addition to existing referral processes) will be needed to gather information and intelligence from all professionals, voluntary sector workers, agency employees and most importantly from children themselves, to identify individuals, groups, locations and behaviours which influence the risk of CSE (and other risks to children). Consideration should be given to how Bexley will encourage and gather information from professionals working with looked after children or persistent missing children. Schools, children's homes, young people's organisations/groups (places where children might share who they are meeting, where they are frequenting) are all capable of identifying and sharing this information. Systems to facilitate this and to understand, disseminate and take action needs to be put in place to improve local understanding of Bexley's CSE profile.

- The prominence of information about vulnerable families is limited in the JSNA and gaps in services have been identified. Examples include: domestic abuse (DA) perpetrators below the level of conviction, CSE victims who do not always want to approach a statutory service in the first instance, and return interviews for missing children currently undertaken by the statutory sector, which is not best practice.

- The interface and remit of Missing Children and Multi-Agency Safeguarding Group (MASE) groups and their relationship with VCG has potential for further improvement. The board had identified this prior to the review.

- Longer term support for CSE victims is limited with service gaps around response and disclosure.

- A workshop on domestic abuse and an event on obesity have been undertaken but there appear to be gaps around the commissioning of responses to other key safeguarding risk areas such as gang activity and neglect.

- There was little feedback to the peer team on key vulnerable groups such as Looked After Children (LAC) and children with disabilities and BSCB should consider how well it maintains oversight of all groups of vulnerable children and young people.

- There are no private fostering notifications, despite a considerable amount of work.

## 7. Key areas for improvement

Following the practice diagnostic, and based on the evidence collected, the peer team provide some suggestions for the BSCB to consider in the short to medium term as follows:

- Give consideration to the wider context of the BSCB workflows which will support an effective cycle of governance processes.

- Further develop a performance management framework for the BSCB which is aligned and co-ordinated across the wider strategic arrangements.

- Improve the quality and tightness of business processes in BSCB

- Ensure the BSCB keeps a focus on all key vulnerable groups while prioritising its work programme.

- You agree that step change is needed - identify how this will be achieved

Through this letter we have sought to outline the strengths of the Bexley Safeguarding Children Board, along with areas for consideration and improvement. You and your colleagues will no doubt now wish to reflect on the team's findings and then consider how they might inform your future plans and activities.

Members of the peer team will be happy to assist you through the provision of examples of notable practice and sharing their experience as independent LSCB chairs and practitioners.

For further improvement support you can contact the LGA's Principal Adviser for London, Heather Wills who can be contacted via heather.wills@local.gov.uk or on 07770 701188.

In addition, you can contact John Harris, LGA Children's Improvement Adviser covering the London region for specialist support. John can be contacted via johnhharris2010@hotmail.co.uk or on 07976 278315.

Yours sincerely

**Peter Rentell**
**Programme Manager (Children's Services)**
**Local Government Association**

**The 'Inspection Information Health Check' analysis grid is attached as Appendix 1 to this letter.**