Richard Williams
Director of Children's Services
Torbay Council
Town Hall
Castle Circus
Torquay
TQ1 3DR

26 June 2012

Dear Richard,

Thank you for taking part in the Children's Services Safeguarding Peer Review. The team received a really good welcome and excellent cooperation and support throughout the process. It was evident to us that all those we met were committed to Torbay and doing the best they could for its children.

We agreed to send you a letter confirming our findings and summarising the action you may wish to take. As you know the safeguarding review is focused on five key themes this letter sets out our findings in each of these. It includes the good practice we noted and areas that you will wish to consider further. Some of the points raised during the feedback session held on 25 May 2012 are also included.

It is important to stress again that this was not an inspection. A team of peers used their experience to reflect on the evidence you presented on safeguarding vulnerable children and young people. Therefore, the emphasis of our findings is about systems, processes and service delivery. Nonetheless we examined 12 case files and 11 supervision files although no service users were interviewed. The findings from these file examinations were discussed with you during the review and the summary report is also attached to this letter. Responses to the staff survey were received from 78 people across the partnership (this report is also attached). There were high levels of 'Don't know' responses to some questions. This supports the peer team's finding that messages were not always clearly and consistently communicated between agencies or right the way through to the front line staff. However, those who responded showed they knew who was responsible for safeguarding and there was commitment to a multi-agency approach to training and development. This was also reflected in the evidence we gathered from those we met whilst we were with you.

Overview of the team's findings

Overall, whilst Torbay knows it has a number of continuing and critical challenges to address, it was clear to the review team that progress has been made in changing the management approach, staff and systems; however this progress remains fragile and needs to be consolidated and built on. From imminent changes in the council's senior leadership, to the significant recruitment and retention issues faced by children's social care there are continued risks to securing a strong and empowered workforce. It was however pleasing that during the course of the review; agreement was reached about new recruitment and retention measures, which should bring further stability and strength to Torbay's children's services. There is a need to understand why people leave and this should form part of the analysis to support these new recruitment and retention measures. The impact of these measures will need to be closely monitored by the Improvement Board (IB).

Much of the progress has been in the past few months, building on the preparations put in place since the establishment of a permanent leadership team. Nonetheless the review team was able to see the beginnings of the impact this is having on staff and on children and families. The Council and the IB should ensure, through performance management and audit processes, that there is a systematic gathering of evidence to assist you in increasing the rate of progress and in targeting your activities. You will need to clarify the respective roles of the IB and TSCB to deliver a faster pace of improvement.

We were impressed by the quality of front line relationships and the evident enthusiasm which pervaded the interviews we carried out. The relationships between schools and the local authority remain strong even though the staffing levels for School Improvement have been reduced. In line with other areas, a number of schools have moved to Academy status and this has led to a determination for senior officers of the council to continue to work closely with Head Teachers. There was good evidence of collaborative work, for example in the monitoring of attendance, and this aspect of work which has led to solid improvement was welcomed by the school representatives that we met.

Whilst understandable given the position Torbay was in, the current volume of child protection plans and children in the care system must be addressed. Children and families require support at an earlier stage, and in a way, which impacts positively on their outcomes. There is now a real need to facilitate decision-making at the lowest appropriate level in line with Munro recommendations; to empower staff and improve confidence. There also needs to be an analysis as to why children with disabilities appear to be under represented. Early intervention services must be better co-ordinated and there should be an improved level of awareness about what is on offer and the impact such services are having in preventing families' problems from escalating.

The strengths we saw in the early help projects and the growing confidence in the new safeguarding hub and family support services give you something to build from. It was recognised that the hub requires a police presence, which will enhance the multi-agency nature and provide benefits to the police in the long-term.

Summary Strengths

- Clear and visible leadership
- Credible and coherent plan
- Enthusiasm and people being up for it
- Approach has introduced much needed systems, processes and security
- Early help projects and approaches
- Positive front-line relationships across agencies

Summary Areas for Further Consideration

- Increasing pace, improving consistency and demonstrating impact on children and families
- Sell your strengths, talk about your improvements and impact, focus on the future, don't be frightened of your past
- Develop relationships that support but are also challenging and drive improvement
- Moving from control to empowered decision making
- Recruitment and retention of safeguarding social work staff – be brave; market 'the brand'; use your staff as advocates; work with others to develop the career offer
- Sustainability – you can't afford to stay as you are, make more use of the whole system working with your partners and other councils.

The peer team concluded that the partnership in Torbay already has a clear plan (the Children's Partnership Improvement Plan (CPIP)) to address the improvement issues. The team noted that changes have already taken place and that although some of these are fairly recent, effort needs to be made to evidence and communicate their impact. The IB will need to review the performance information it receives in order to assess impact on outcomes and enable faster progress.

There is a political will to resource frontline safeguarding and there is recognition of the increased demand for services, particularly within the looked after children provision. We must be guarded, however, about how far that can be delivered given the overall financial position of the Council and its potential, to achieve significant economies of scale or savings in other areas unless it looks at how it can do this together with other partners locally or regionally. The current health reforms are also likely to have an impact including the increase in frontline health professionals, some of whom may require training and so affect the existing staff's ability to offer early help.

There was evidence of good relationships between agencies; the partnership should now develop the capacity to undertake even more challenge between members. Looking forward, the authority, with the rest of the partnership, is in a position to develop a clear and ambitious vision for its children and to increase the rate of progress so that it is able to come out of intervention as soon as possible.

The table below highlights the good practice noted by the Peer Review team.

Outcomes	• Outcomes for teenagers – low offending rates; numbers in education employment and training at 16; significantly improved educational outcomes for children in care • Political support for safeguarding children • TellUs Survey (2011) – most children feel very safe at home • Financial and accommodation commitments made, followed through and having positive impact
Vision, Strategy and Leadership	• Cross-party support and commitment to improve safeguarding – particularly corporate parenting • Strong, clear vision and actions in the Children's Partnership Improvement Plan • Confidence in the stable 'top team' leadership • Addressing cultural change – honesty, frankness, inclusivity • Recognition of need for sustained action on recruitment, development and retention
Working Together and the TSCB	• Child's Journey/Threshold Matrix – clear, strong roll out and visible support • Remodelling of the TSCB with clarity of priority areas for change and openness to challenge and development Collaboration with other LSCBs on training
Service Delivery and Effective Practice	• Joint sharing of professional anxieties • Excellent support for management of allegations • Family Health Partnership • Social work practice • Child Abuse Investigation Team • Real commitment to early help • Front-line relationships/co-location • NQSW/Grow your own/Training and Development • Creative use of staff, including secondments • Safeguarding Hub • Intensive Family Support Service • Perinatal mental health team
Managing Resources	• Evidence of some decisive action regarding poor performance • Evidence of increasingly intelligent commissioning to improve quality, outcomes and value for money • Evidence of managerial direction in case work

The table below highlights areas the Peer Review team felt would benefit from further consideration.

Outcomes	• Evidence of impact of the changes made so far should be available now but must be in future • How is impact on outcomes evidenced– the 'so what' question? • High numbers of children with Child Protection Plans and in the care system is not sustainable and is likely to impact on outcomes and safety
Vision, Strategy and Leadership	• How will you secure more effective challenge and a faster pace of action, for example recruitment and retention • Children as a long-term political priority against competing demands: economic development, tourism, link road • Other partners understanding, engagement with and shared leadership of both the Improvement Plan and the future strategy/use of resources • Clarify and communicate the early help strategy and offer in order to secure on-going investment in the right places
Working Together and the TSCB	• Demonstrate consistent involvement and challenge of all agencies • Resolve the lack of clarity about ownership of SCR/IMR actions and learning between TSCB and the IB • Develop capability and capacity through further learning and joint work with other LSCBs • Case audit framework needs further development to demonstrate an impact on practice/outcomes • Draw upon the strengths and expertise of the Voluntary Sector
Service Delivery and Effective Practice	• Ensure that positive developments (Hub/IFSS/CAF) are not swamped because the overall strategy is not clear. • Achieving a better balance between assessment and intervention • Delivering on your commitment to reduce caseloads • Equality and Diversity issues – not well understood and embedded • CWD services geographically and structurally too separate from social care • Decide and communicate the level of partner access to PARIS
Managing Resources	• Develop systematic approaches throughout the partnership (including the IB and TSCB) and at every level which ask the 'so what' question and rigorously look at the impact of changes

	• Raise awareness of Children's Safeguarding performance information and strengthen use of hard and soft data to understand issues and target improvement • Consider how good performance is identified and communicated • Evidence the impact of improved, reflective supervision and developing peer support • Developing a sustainable strategy to reduce the number of children in the social care system

From the evidence presented to them, the team also provided the following summary issues for you:

- Positive change has definitely happened – the pace of change now needs to be increased and its impact for children and families clearly articulated
- Staff report the situation is safer than it was – evidence to corroborate this needs to be compiled and reviewed by the TSCB and IB
- Urgent action to recruit and retain social workers is critical
- Your long term strategy for life after the improvement notice needs early and sustained development involving all partners. This is not a problem or solution for social care or children's services alone
- Communicate between partners that things are moving – again, the use of performance measurement and impact data will support the transparency of the improvements in service delivery and outcomes for children and families
- You have calmed and controlled – now empower!

At the feedback session on 25 May 2012 you and your colleagues received the findings from the Peer Review team and raised the following points in discussion:

- The turnover levels in social work staff are concerning. This may indicate improvements are required in the selection process e.g. the use of psychometric tests. However it is essential to understand the reasons people leave, through for example exit interviews and to respond urgently to the issues identified.
- There was understandable concern that communicating perceived successes could invite external criticism. Improved measurement of impact will provide evidence to support external communications. There was recognition of the need to be '"brave" to demonstrate achievements and to ensure that all members of the partnership were included in and aware of communications
- Pace and motivation need to be based on confidence that the safeguarding of children is improving. The challenge to the partnership is to use the peer review finding as a springboard for delivering and demonstrating improvements
- It was recognised that more needed to be done to promote and address equalities and diversity. This is not just about ethnicity and a greater awareness amongst all partners of issues of identity and disability is required
- Elected members are determined to support staff and want to know more about what they can do to help. There is a determination to succeed and an understanding that tackling economic and wealth creation issues will also have an impact on helping Torbay's children

- There had been positive feedback from the people who had contributed to the review through the interview and focus group process. There was also a desire to use the feedback to further improve safeguarding and briefings had been booked with partners and elected members. There was also a wish to book a follow-up review in a year's time to check on and stimulate further progress.

Torbay is an authority that acknowledges it is facing significant challenges both in terms of scale and in the changes it is making to address the needs of its population. In the peer teams view you should now be placing an emphasis on reducing the numbers of looked after children and children requiring child protection plans through better early help. This should be given more prominence, greater investment and be implemented at faster pace.

You and your colleagues will want to consider how you incorporate the team's findings into your improvement plans, including how to make the best use of the sector support available through the Children's Improvement Board. Claire Burgess, your regional Children's Improvement Advisor, has been sent a copy of this letter and will be in touch with you to discuss the options for support. She can be contacted by either email: Claire.burgess23@gmail.com or by phone on: 0785 4407 337.

Thank you again for agreeing to receive a review and everyone involved for their participation. In particular, please pass on thanks from the peer review team to Samantha Poston and her team for their fantastic support in preparing for and organising the on-site review and for looking after the team whilst they were with you.

Yours sincerely,

Paul Curran
Children's Improvement Adviser (Peer Review), Local Government Association

Analysis of self-evaluation questionnaire responses

1. Headlines

There were 78 responses to the questionnaire received by the deadline of 08/05/12, gathered from across the range of local partners. However, a number of respondents left questions blank. The base number of respondents is therefore given for each question (this went as low as 61 for some questions).

Verbatim comments from some respondents have been included to provide an illustration of people's contributions.

The number of responses by area of work and partner agency is set out below:

Area	**Number of responses**	**% of responses**
Frontline	44	60%
Team or middle manager	18	24%
Senior manager	11	15%
Councillor or a non-executive role	01	01%

Partner	**Number of responses**	**% of responses**
NHS	17	28%
Primary/secondary school or a college	12	20%
Police or criminal justice	0	0%
Community or voluntary sector	07	12%
Social care	0	0%
Early Years	11	18%
Youth services	0	0%
Other	13	22%

- Under half of the respondents were confident that safeguarding works well (46.5%), that the LSCB holds agencies to account (31.7%), that the Children's Trust/LSCB provide effective leadership (47.7%), that office and other facilities were fit for purpose (38.5%), that children are always seen alone (27.9%), that

accurate performance information is available (21.5%), that children and young people are appropriately involved in decisions (38.5%), that child protection referrals are dealt with in accordance to LSCB procedures (33.9%), that child protection services are meeting the diverse needs of the community (26.6%) and non-specialist staff know what to do if they are worried a child is at risk (43.8%).

- Only 6.2% of respondents said that there were sufficient frontline staff
- There was strong support for the benefits of multi-agency training, with 93.8% of respondents giving a positive response
- The support for learning opportunities was less strong with just over half of the respondents 55.4% saying that they regularly learnt from research and best practice
- It was clear that the majority of respondents (92.3%) knew who can make safeguarding decisions
- Supervision given to frontline staff was seen as good by 57.8% of respondents. However, it was felt by some that quality varied between managers
- A significant number of respondents selected "Don't Know" to questions, with more than half giving this answer to the following: are there sufficient frontline staff (53.8%), are children/young people seen alone (63.9%), are arrangements for dealing with professional differences working effectively (64.6%), are children and young people appropriately involved in decisions affecting them (56.9%), are child protection referrals always dealt with in accordance to LSCB procedures (54.8%) and are child protection services meeting the diverse needs of you community (59.4%).

2. Findings in more detail, by question

Q5. How confident are you that your multi-agency safeguarding procedures are working well?

(The respondent base for this question = 71)

33 (46.5%) of respondents from across the range of partners reported they felt "confident" (43.7%) or "very confident" (2.8%) that multi-agency procedures work well.

Over a third of respondents, 40.8% (29 people) said they were "neither confident or not confident".

11.3% of respondents (8 people) said they were "not confident" and one person (1.4%) that they were "not very confident at all" that multi-agency safeguarding procedures are working well. Concerns were raised about poor communication by the majority of those commenting including: "with the current changes to process happening we are not receiving clear information as to when changes are happening, so consistency for staff is poor, feels a bit disjointed" and " low level concerns are not taken seriously, there is often poor communication with information not shared". Also, there were concerns raised over organisations not being clear about the responsibilities and activities of other partners; "It is apparent that some organisations are unsure of others role, boundaries are being overstepped, duplication of work is being completed, this is can be confusing for the client as they do not know who is supposed to be doing what" and "schools and wider Local Authority colleagues are not sure of who they need as a point of contact".

Q6. Does the Children's Trust give enough priority to safeguarding?

(The respondent base for this question = 70)

60% of respondents (42 people) said that the Children's Trust does give enough priority to safeguarding. Two respondents commented on the difficulties of delivering in a multi-agency environment; "the will is there to make safeguarding a priority, but it is such a wide issue over so many agencies that it is difficult to retain the needs of the children at the forefront of all".

Almost one third, 23 colleagues (32.9%) selected "don't know". Two people commented that they did not know that the Children's Trust still existed with another offering the following clarification: "Note - Childrens Trust now delivered through the Health and Wellbeing Board".

Five respondents (7.1%) stated "No".

Q7. How would you rate the arrangements for information sharing?

(The respondent base for this question = 70)

51.4% of respondents (36 people) rated information sharing arrangements as "good"; no one rated them as "very good".

31.4% of respondents (22 people) said that arrangements were "neither good nor poor".

14.3% of respondents (10 people) stated that information sharing was "poor"; no one stated "very poor".

2.9% of respondents (two people) said that they "don't know".

There were 31 comments made in response to this question giving a mix of views. It was acknowledged that there are areas of good practice (access to the PARIS system helps communications) and hope that things will continue to improve with the arrival of the "Hub". However, there were also complaints that telephone is still the best way to get information, that teams "lock down" information and that communication is often perceived as being one way with little feedback.

Q8. Is the Local Safeguarding Children Board (LSCB) holding individual agencies to account effectively?

(The respondent base for this question = 63)

31.7% (20 people) said that the LSCB did hold agencies to account.

The majority of respondents, 61.9% (39 people) said they did not know if the LSCB held agencies to account. There were comments that little is known about the LSCB; "there is little communication from the LSCB about their vision, priorities and how they follow things up". There was also criticism that the LSCB does not hold agencies to account; "no clear oversight or scrutiny done from peer to peer leaving grey areas of knowledge and thresholds" and "possibly too much, in singularly holding one agency to account rather than all agencies taking a shared responsibility for poor outcomes". On what else the LSCB should be doing one respondent stated,

“Poor attendance at many Child protection Meetings by many agencies needs to be addressed”.

Four people (6.3% of respondents) reported that the LSCB did not hold agencies to account effectively.

Q9. Are you clear about who can make safeguarding decisions in respect of individual children?

(The respondent base for this question = 65)

60 respondents (92.3%) stated that, yes they were clear.

Two people (3.1%) said that they were not clear and three (4.6%) said that they did not know. Two comments were posted that queried the question; one asking about the type of safeguarding decision and the other the setting (local authority or other agency) for the decision.

Q10. Are members of the Children’s Trust and the LSCB providing effective and visible leadership in regard to safeguarding?

(The respondent base for this question = 65)

47.7% of respondents (31 people) stated that the Children’s Trust and LSCB provide effective and visible leadership in regard to safeguarding.

24 respondents (36.9%) responded with “don’t know”.

10 colleagues (15.4%) reported that effective and visible leadership was not provided. Suggestions on how to improve included: more regular feedback to frontline staff, more visible senior management (although RW was mentioned as visiting team meetings) and more inter-agency information exchanges to engender better understanding, cooperation and mutual respect.

Q11. Is the learning from reviews such as Serious Case Reviews and Child Death Reviews, inspections and audit effectively shared with frontline staff?

(The respondent base for this question = 64)

53.1% of respondents (34 people) said that the learning is effectively shared with frontline staff.

17 colleagues (26.6%) selected “don’t know”.

13 respondents (20.3%) said that learning was not effectively shared with the frontline. It was acknowledged that events are open for people to book themselves on (and the information received regarded highly). However, not many people do book themselves on to the events and change in practice as a result of the findings is not widely seen. Suggestions for improvement included; better communication via secure email or internet site.

Q12. Are there sufficient frontline staff to meet the need for safeguarding services?

(The respondent base for this question = 65)

6.2% of respondents (four people) from across the range of partners, said there were sufficient frontline staff.

Over half of the respondents 53.8%, (35 people) reported that there were not sufficient frontline staff. Shortages in children's services were highlighted with people commenting; "there always seems to be a shortage of staff from childrens services on a Friday afternoon" and "there are not enough frontline staff at Children's services as it is often hard to contact individuals (presumably because of workload)". It was acknowledged that shortages in Health Visitor numbers was known about and is being addressed.

26 respondents (40.0%) responded "don't know".

Q13. Are the office and other facilities available to frontline staff fit for purpose?

(The respondent base for this question = 65)

38.5% of respondents (25 people) said that the facilities were fit for purpose.

11 respondents (16.9%) stated that the office and other facilities were not fit for purpose. Comments included; people not responding to requests quickly enough, teams being based on a number of locations (not being co-located), insufficient/inappropriate rooms for multi-agency working and better use of mobile technology.

A further 29 respondents (44.6%) stated "don't know".

Q14. Is your multi-agency training helping you deliver a better service?

(The respondent base for this question = 65)

93.8% of respondents (61 people) said that training was supporting a better service. One respondent said, "Feedback from our own audits indicate that those staff who have received training are better equipped and more confident in dealing with a Safeguarding issue, than those who have not received training." However, another commented that, "it is challenging to send all staff on the appropriate training due to capacity issues and some training not being easily accessible".

Two respondents (3.1%) said that training was not supporting a better service. A comment was made that: "Although it does help improvements could be made by ensuring training involves more detail on practical process and delivery and less on theory."

Two respondents (3.1%) selected "don't know" with a comment that, "not had multi agency training, would be interested in knowing more about who delivers this".

Q15. Is safe recruitment practice consistently used?

(The respondent base for this question = 65)

Just over half, 53.8% of respondents (35 people) said safe practice was consistently used.

40.0% of respondents (26 people) said they did not know.

Four respondents (6.2%) stated that safe practice was not consistently used. Three comments were made about the need to improve training including “As far as I am aware only schools and some areas of Children's Services have had access to the Safer Recruitment workshop developed as a result of the Soham Public Enquiry. There needs to be a commitment to roll this out to all managers in all agencies to ensure those responsible for recruitment and selection are trained in safer recruitment practises."

Q16. Is the supervision offered to frontline staff of good quality?

(The respondent base for this question = 64)

57.8% of respondents (37 people) said that supervision to frontline staff was of good quality. However, comments were made that it was of variable quality; “I think the quality of supervision varies. We currently have a good system for identifying who has had supervision, but not the quality of it” and “Although some managers and services adhere to best practice in this area a lot don't and better monitoring needs to be put in place by middle managers”.

Nine respondents (14.1%) said that supervision of the frontline was not of good quality. Three comments indicated that they had had no supervision or were aware that others had not received any supervision.

18 respondents (28.1%) said that they did not know.

Q17. Are paper and electronic case records in your agency accurate and up to date?

(The respondent base for this question = 64)

53.1% of respondents (34 people) stated that both paper and electronic files were up to date.

Four (6.3%) respondents said that only electronic records were up to date.

15.5% of respondents (10 people) said that only paper records were up to date. Four comments were received that there was limited or no access to computer equipment: “limited access to computers at one work base some difficulty/frustration getting 'health and council' staff using computers in both settings”

Five (7.8%) respondents said that records were not up to date, with one person commenting “My caseload is so high that I just can't keep my recording up-to-date. This is a source of constant concern to me.”

11 (17.2%) of respondents said that they did not know.

Q18. Are children/young people subject to safeguarding procedures always seen alone?

(The respondent base for this question = 61)

27.9% of respondents (17 people) said that children subject to procedures were always seen alone. One respondent offered the caveat, “I am told that they are.”

A significant majority of the respondents 63.9% (39 people) said that they did not know.

8.2% of respondents (five people) said that children were not always seen alone. There were comments that the context of the situation needed to be taken into account; “I don't believe this is automatically necessary in my line of work but when it is indicated it is difficult due to time pressures and lack of environment/ chaperone where necessary, so tends not to be pursued as often. I think there are areas of good practice”. Another commented that it was a social workers responsibility; “Within our service we are led by what response there is from social services when we make a safeguarding referral as it is their remit”.

Q19. How regularly are you given opportunities to learn from research and best practice?

(The respondent base for this question = 65)

55.4% (36 respondents) said that they were regularly given the opportunity to learn from research and best practice.

16.9% (11 respondents) said that the opportunities were irregular.

15 respondents (23.1%) said that they were rarely given the opportunity. Lack of time was mentioned by six respondents. One respondent commented, “There are fewer opportunities now to learn from research and best practice now that we are no longer able to go to conferences outside Torbay and do not have access to hear national speakers. Information is now cascaded to us”. Suggestions for improvements included; “there is resource on swcpp - supervision and other opportunities in day to day practice e.g. team meetings might help to be more familiar with sources, and would make sense if using around actual cases”.

One person (1.5%) responded that they “never” had the opportunity to learn.

Two people (3.1%) said that they did not know.

Q20. Is accurate performance management information available to all relevant staff?

(The respondent base for this question = 64)

37.5% of respondents (24 people) said that performance information was available. Comments were somewhat equivocal and included; “Assume it's accurate - available on Trust website” and “I have to collect information manually as the authority's database is unreliable and only as good as the information input. Some staff are unaware of the need to record dates, etc, accurately (particularly managers!)”.

48.4% of respondents (31 people), said they did not know.

Nine colleagues (14.1%) said that the information was not available. Comments included; “No infrastructure to do so currently” and “I have received no performance management” and “Performance management is not yet embedded into the organisation through regular quality supervision, observation and feedback, induction and training opportunities evidencing changes to practice”. However, one respondent noted that; “we are in the process of introducing this now”.

Q21. Are current children in care priorities for improvement the right ones?

(The respondent base for this question = 63)

61.9% (39 respondents) said the improvement priorities were right.

36.5% of respondents (23 people) did not know. Two comments were made on the lack of consistent, clear priorities; “I think so but am concerned about the lack of clarity about local demographic and the plan being mapped to that” and “priorities change regularly. The CPIP will hopefully address many of the issues if Partnership working is effective”. Two others expressed fears over referrals; “I personally have concerns around the Child's Journey Safeguarding Matrix- I feel that Independent Early Years Settings will not immediately refer a safeguarding risk into Children's Services” and “it concerns me that there is a steer towards frontline workers taking on more responsibility to do referrals etc for CAF etc and this moves aware more from social workers”.

One respondent (1.6%) said that the improvement priorities were not the right ones.

Q22. Are the arrangements for dealing with professional differences working effectively?

(The respondent base for this question = 65)

21.5% of respondents (14 people) said that the arrangements worked effectively.

Over half of the respondents, 64.6% (42 people) said they did not know.

Nine respondents (13.8%) said that arrangements did not work effectively. Comments received included, improved information and training on the “escalation” procedures is required (five comments). There were also two comments expressing concern over the adverse impact of how differences are dealt with; “The few cases I have dealt with people became very emotional and the process became 'too difficult' and not resolved” and “Those leaving tell of being effectively forced out because they have criticised senior managers and have not been able to deal with professional differences”.

Q23. Are children and young people appropriately involved in decisions affecting them?

(The respondent base for this question = 65)

38.5% of respondents (35 people) said that children and young people were appropriately involved in decisions. There were three comments specifically stating that schools involved their children.

Over half of the respondents, 56.9% (37 people) said that they did not know.

Four respondents (6.2%) said that children were not appropriately involved. Two respondents stated that more use could be made of advocates and another made the following observation, “I think that children and young people are too often expected to confirm a formal adult way of doing things rather than ensuring that their opinions are sought in a way that they can relate to. Also, I have attended many LAC reviews where it seems that each adult in the room has something critical to say about the child or young person while few, if any, of them have anything positive to say. This does not give the young person much confidence that they are a valued part of the process”.

Q24. Are parents and carers effectively involved in case conferences?

(The respondent base for this question = 63)

54.0% of respondents (34 people) said that parents and carers were effectively involved.

Four people (6.3%) said that parents and carers were not effectively involved in case conferences. There were two comments received expressing concern over parents involvement in case conferences; “parents often feel under constant criticism and scrutiny” and “ feedback has been that clients can feel disempowered”, with the following suggestion for improving the situation, “They could be given an agenda in advance of the meeting to know what is going to be discussed, and this could be discussed with someone prior to the meeting if the parent has low literacy levels so that they can adequately prepare.”

39.7% of respondents (25 people) said that they did not know.

Q25. Are child protection referrals always dealt with according to your local LSCB procedures?

(The respondent base for this question = 62)

33.9% of responses (21 people) stated that referrals were always dealt with in accordance with local procedures.

Seven people (11.3%) said that local procedures were not always used. Comments from the respondents focused on feedback on referred clients not being received (three out of ten comments) and referrals not being dealt with within the specified timescales (three out of ten comments).

Over half of the respondents 54.8% (34 people) said they did not know.

Q26, Are child protection services meeting the diverse needs of your community, and reaching vulnerable and under represented groups?

(The respondent base for this question = 64)

26.6% of respondents (17 people) said that services were meeting the needs of the vulnerable and hard to reach.

Nine (14.1%) respondents said that services were not meeting those needs.

Over half of the respondents, 38 (59.4%) said they did not know.

In response to the question; 'which groups or children are not being offered a good service?' there was no consensus on specific groups. Comments included: "Black and minority ethnic groups", "Young people who go missing", "families that are living in refuge spaces", "families that come out of area", "mental health - both child and adult" and again "neglect and mental health issues".

Q27. Do you think all non-specialist staff (e.g. school classroom assistants, GP receptionists etc) know what to do if they are worried a child is at risk?

(The respondent base for this question = 64)

43.8% of respondents (28 people) said they thought all non-specialist staff knew what to do if they were worried a child was at risk.

34.4% of respondents (22 people) said they did not think all non-specialist staff knew what to do. Suggestions of how to remedy this centred on increasing training (14 out of the 23 comments registered) with other, specific suggestions of; "Audit across the patch (mystery shopper approach)" and provide a "clear flowchart".

21.9% of respondents (14 people) said they did not know.

Torbay Peer Review 21st – 25th May 2012

Summary of case analysis

Introduction
Members of the Peer Review team undertook an examination of 12 case files, randomly chosen from a list of cases provided to the team by the authority. For each case there was both an examination of the case file, followed by a discussion group with practitioners and managers involved in the case. In addition, a sample of 11 supervision files were examined.

A summary of the findings is provided below.

The Case Files

1. Basic data about the child and family was complete and up to date in the majority of cases, with the exception of one case where ethnicity was not recorded.

2. Basic details about health and education components within the case records were missing in a minority of cases.

3. Chronologies were present in most of the cases, but some were a list of ICS events rather than a coherent description of significant events which could tell the story of the case.

4. Four Core Assessments from the sample were examined in detail and all were completed within the 35 day timescale. There were examples of good and very good analyses within these Core Assessments. The long tick box format of the Core Assessments seemed unhelpful, repetitive, not user friendly and was clearly time consuming for social workers to complete. Many other children's services departments have replaced this format with a broader set of headings which facilitates a narrative and allows the child and parent's viewpoint to be well represented.

5. Within the sample there was one example of a completed CAF which provided a good narrative but did not lead to a coherent plan.

6. There was evidence of good practice direction from chairs of Child Protection Conferences and some good examples of child protection plans which gave a clear outline about what help would be provided to the family in order to facilitate change. These plans were user friendly and easy to follow and were all in the format which we understand has now been modified. The Peer Reviewers felt that the proposed new version is more cumbersome and would be less accessible to families. It may be of value to do further work to combine the strengths of both formats.

7. The case files showed plenty of evidence of managerial direction and supervision which cross referenced with supervision files. Frequency of supervision as evidenced in supervision files was however very patchy, although significantly improved in almost all cases from late 2011 through to May 2012. Not all supervision sheets were signed and dated.

8. The case files do not do justice to the understanding and insight of social workers and allied practitioners which emerged during the discussion groups. Much of this is due to unhelpful formats/templates which would benefit from radical streamlining.

Practitioner discussions

9. In the majority of the discussions held, social workers, other agency practitioners and managers spoke intelligently, with a depth of understanding about complexity and with a clear child focus. We heard about casework which was purposeful and of practitioners building and maintaining good relationships with parents which had contributed to positive outcomes for children.

10. There was clear evidence of effective multi-disciplinary working and we witnessed professional dialogue between staff from different disciplines in which they showed a good understanding of their differing roles and responsibilities.

11. In these discussions, practitioners from other agencies spoke positively about various new initiatives including the Safeguarding Hub, and of recent changes which had promoted multi-agency working and a more responsive service from children's social care than they had experienced in recent years.

12. These positive observations were however countered by a recognition that the quality of social work practice remains uneven. Where there are permanent staff teams with good Practice Managers there was clear evidence of good social work practice. Some agency staff were well respected but in cases where there had been a high turnover of staff, there were instances of drift and lack of proactive action and a continuing concern about the impact on children and families. There was evidence that children and families who had received a consistent social worker over time had benefited from a trusted relationship and been able to make significant progress.

13. We heard of families achieving change through the support of Family Support Workers and Community Care Workers providing tried and tested programmes such as Triple P and Keep Safe work. There were some concerns expressed that the intervention was resource led i.e. that families received the services that were available and that a wider repertoire of interventions would enable a more needs led approach.

14. Busy social workers were limited in their capacity to provide direct work to families and much of the actual intervention programmes were provided by non social work staff. Despite this we heard of examples of social workers working with parents to reduce domestic abuse and of a keen interest to be empowered to do more direct work with both children and parents.