John Harris
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Sandwell Safeguarding Children Board
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11 July 2016

Dear John

SANDWELL SAFEGUARDING CHILDREN BOARD DIAGNOSTIC

Thank you for taking part in the Sandwell Safeguarding Children Board (SSCB) Diagnostic, which I hope you found helpful. It was evident from the staff and partners we met that everyone was open and honest and committed to safeguarding children in Sandwell.

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 SSCB, its key strengths and areas for improvement. The team interviewed over 50 key stakeholders, either individually or as part of focus groups, as well as undertaking a comprehensive review of current documentation and an Audit Validation exercise of the SSCB's multi-agency audits. Unfortunately due to a variety of unavoidable circumstances it was not possible for the team to meet with all relevant senior members or officers and the findings, therefore, are based on interviews with those stakeholders the peer team did meet.

We are particularly grateful to Raj Bector and his colleagues for the efforts they put into preparing for and supporting our visit and we very much appreciated the way that everybody engaged in the process. The people we met were very welcoming and demonstrated a willingness to use the peer diagnostic as an opportunity for learning. We recognise that many of these people made themselves readily available to us at short notice and we thank them for their flexibility.

This letter sets out in detail our findings, which were initially presented to an invited audience at the conclusion of the diagnostic.

Our findings are set out under the following headings:

- An Executive Summary
- Board Effectiveness
- Quality Assurance and Performance Management
- Audit Validation
- Compliance with Working Together 2015
- Key Safeguarding Risk Areas (CSE, Thresholds and Early Help)
- Recommendations
- Appendix 1 – Audit Validation report

1. Executive Summary

The diagnostic was undertaken at the request of the SSCB who requested it in order to validate progress since the Board's Strategic Review in September 2014 and identify areas for further improvement.

The Board's Strategic Review in September 2014 acknowledged that the Board was not meeting statutory duties and a ten-point improvement plan was put into place as a result. Ofsted reviewed the SSCB shortly after (in February 2015) and whilst acknowledging progress made, judged the SSCB to be 'inadequate' Ofsted's judgement looked at progress since the previous inspection in 2013, when the SSCB was first identified as inadequate. Many of the issues highlighted by Ofsted in 2015 had already been picked up by the strategic review but Ofsted acknowledged that work on improvement was at an early stage. The following paragraph 177 of the 2015 Ofsted report stated: 'From a low base, the work of the LSCB is now going through a necessary and rapid period of development. This is based on a new 2014-15, 10 point business plan presented to the Board in October 2014. This stemmed from the strategic review and is aimed at moving the Board to a position where it is able to fully discharge its statutory functions within six months. A workshop event for Board members on 15 January 2015 considered how to make this vision a reality. This provides a clear route map for progress but it remains too soon for a significant impact to be seen'.

The diagnostic also came at a very significant time with two other factors coinciding:

- Recent publication of the Wood Report and Government Response on the role and functions of Local Safeguarding Children Boards
- The recent announcement by the Independent Chair of SSCB that he would be standing down as Chair at the end of July at the end of his contract.

It was evident to the peer team that the SSCB has made huge progress since the last Ofsted inspection and that it is now fulfilling its statutory requirements. A significant foundation for this improvement was the decision of the SSCB to commission three external audits to provide an independent perspective as regards key areas of safeguarding risk. Not only did these audits examine specific issues around Thresholds, Early Help and Child Sexual Exploitation

(CSE), but they also signaled that the SSCB could provide authoritative and constructive challenge to enable the Local Authority and partners to reflect upon key issues of substance identified in Ofsted's inspection of Children's Services.'

It was also notable that the SSCB undertook a self-assessment in preparation for the diagnostic and the peer team found itself in agreement with all the major points of that self-assessment. This is commendable as the self-assessment demonstrated a good self-awareness of the value of the work that has been done but also identified areas where the SSCB still knows that improvement is required.

An outstanding feature of the diagnostic was the universal enthusiasm of all the people the team spoke to and their commitment to improve their services and collective working still further in order to safeguard and improve opportunities and outcomes for children in Sandwell.

This enthusiasm and the work collectively undertaken mean that the Board now has all the basic building blocks in place to progress your work. You also know where your priorities lie for this future work. It is important that having reached this stage that you ensure that this work is 'reaching the ground' and is embedded and impacting upon frontline services.

One of the criticisms of Ofsted (and which was also picked up in the Strategic Review in September 2014) was that there was a lack of collective challenge amongst partners and of holding services to account. During discussions the peer team received consistent feedback that constructive challenge (including regarding attendance) was greatly improved. There was not a consistency in opinion, however, as to whether this was due to a collective culture of challenge or whether it was primarily from the Independent Chair. This is an area the SSCB should consider further and it is suggested that it finds a means to evidence where such challenge is happening in order to judge its effectiveness.

The peer team consider that the membership of the Board is currently too large and that there are too many sub-groups. This was also the opinion of the vast majority of people spoken to. It is accepted that the current membership and structure probably was necessary in order to provide an inclusive approach and specialism within sub-groups to tackle the challenges identified at the time of the Ofsted inspection. It was also important that the focus of activity was on creating a purposeful work programme linked to a robust business plan and re-structuring may have diverted that focus. However, it is now time to streamline the structure and membership and in doing so take account of the context of the Wood Report.

The SSCB has made a significant contribution to the work of the local authority and partners locally to ensure more consistent understanding and application of thresholds; improving engagement in early help, and in responding to CSE. The Board has commenced work to improve in some key service areas including Faith, Culture, Emerging Communities and incorporating the Voice of the Child but it is also aware that these specific areas require further development.

It is clearly evident, therefore, that overall the SSCB has improved greatly the way it works, bringing together key partners, the development of policy and key guidance and its focus on specific safeguarding issues. The SSCB is aware that it now needs to consolidate and evaluate the impact of its work on multi agency front line services. The peer team suggests that a first step to this should be a collective consideration as to what the SSCB understands by its impact. To support this the work that has been commenced to improve the quality of the multi-agency audits would be beneficial.

The SSCB is now at the start of the next phase of its development and, as stated, all the basic building blocks are now in place, including a clear and focused Business Plan based on identified priorities to progress the work of the SSCB. In addition in May 2016 an Assurance Activity report was undertaken which was used to pull together key themes from the learning and improvement framework to inform new business plan priorities.

The main challenge is to maintain the momentum that has been generated but the peer team considers that the SSCB has good self-awareness and has demonstrated a commitment and ability to improve opportunities and outcomes for children in Sandwell.

Main Findings

2. Board Effectiveness

It was evident to the peer team that the SSCB has made huge progress since the last Ofsted inspection and that it is now fulfilling its statutory requirements. A significant foundation for this improvement was the decision of the SSCB to commission three external audits to evaluate front line practice. Not only did these audits examine specific issues around Thresholds, Early Help and Child Sexual Exploitation (CSE), but they also signalled that the SSCB could provide authoritative and constructive challenge to enable the Local Authority and partners to reflect upon key issues of substance identified in OFSTED's inspection of Children's Services. In addition it is evident that the drive and energy of the Independent Chair has had a major influence and this was confirmed by all partners. The Independent Chair has now confirmed that he will be stepping down at the end of July when his contract expires. It is essential that the SSCB works collectively to maintain the momentum it has built and that key Board partners are clear in what they see as the role of the new Chair and appoint accordingly. Independence should continue to be a key aspect of the new appointment.

The progress made has been supported by four major factors created by the SSCB:

- A clear and focused Action Plan based upon the priorities identified in the Strategic Review and the Ofsted report
- A clear means of monitoring progress on the Action Plan
- Improved performance data and business management
- A clear governance structure for the SSCB

In addition to these the peer team were impressed with the commitment, professionalism and support provided by the Business Manager and his Business Unit. All partners spoke highly of the services of this team and recognised the significant improvements in communication and presentation of SSCB business that they have implemented. Care should still be taken, however, to ensure timescales and 'Action Owner' are included in all minutes and action plans. The Chair of each meeting needs to ensure that discussion takes place so that decisions are clear and can be recorded to ensure that action is followed up.

The Business Unit has been instrumental in devising and bringing together a clear and focused Business Plan based on identified priorities arising from the Board's Assurance Activity report, which pulled together key themes from the learning and improvement framework. Whilst the Plan had input from partners represented at the Chairs' Group it did not benefit from a wider shared planning process involving the wider Board.

As a consequence of all the above factors the SSCB is more visible, valued by its members and partners, and viewed to be 'bringing things together'. The Board has been willing to explore new ways of working and ensuring time for consideration and development of its activities. In particular the recent model of including development time at meetings has been well received.

In addition work on embedding the Voice of Child has started but is recognised by the SSCB that it requires further development. The SSCB self-assessment states that 'the experiences of children and young people are not presently used as a measure of improvement in the Board's audit activity'.

Although the governance structure has been successful, the peer team considers that the membership of the Board is currently too large and that there are too many sub-groups. This was also the opinion of the vast majority of people to whom we spoke. It is accepted that the current membership and structure probably was necessary in order to provide an inclusive approach and specialism within groups to tackle the challenges identified in the Strategic Review and the Ofsted review. However, it is now time to reduce the membership of the Board as this is hindering detailed discussion at meetings and to streamline the structure of sub–groups. Allied to this there is ambiguity as to whether the Chairs Group is a co-ordinating mechanism and/ or an Executive (see also section 5 of this letter). This ambiguity should be resolved and, when doing this, the recommended principles in the Wood report should be taken into account.

One of the criticisms of Ofsted was that until recently there had been a lack of collective challenge amongst partners and of holding services to account. During discussions the peer team received consistent feedback that constructive challenge (including regularity of attendance at the main SSCB meeting) was greatly improved. There was not a consistency of opinion, however, as to whether this was due to a collective culture of challenge or whether it was primarily from the Independent Chair. This is an area the SSCB should consider further and it is suggested that it finds a means to evidence where such challenge is happening in order to judge its effectiveness.

It is clearly evident, therefore, that overall the SSCB has improved greatly the way it works, the development of policy and key guidance, and its focus on specific safeguarding issues. The SSCB is aware that it now needs to consolidate and evaluate the impact of its work on front line services. The peer team suggests that a first step to this should be a collective consideration as to what the SSCB understands by its impact. To support this, the work that has been commenced to improve the quality of the multi-agency audits would be beneficial. In addition regular reporting on impact through case studies could be used.

The SSCB has made good progress in examining approaches to reducing CSE, creating clear Thresholds and improving Early Help (as discussed in greater detail in section 6). The Board has commenced work to improve some key service areas including Faith, Culture, Emerging Communities and incorporating the Voice of the Child. An example of the Voice of the Child discussed at the Chairs group meeting was through the work of the 'See me, Hear me' pilot which has involved children and young people. The local Sandwell SHAPE group organised a "Take Over" of a SSCB meeting and this was followed up by an invitation to address the Sandwell Borough Police Inspectors. SSCB will be working with SHAPE as their regular "voice of the child". The Board is aware, however, that more needs to be done in this area and children and young people could be involved in the next Section 11 audits.

The Signs of Safety model provides the opportunity to gather the Voice of the Child, and more needs to be done to obtain the view of the child during the Independent Review process as this appears to be underdeveloped. Extending the use of the Signs of Safety model to the IRO team would be one approach and there are bespoke systems for gathering children's voices in reviews. Consulting the Participation Team on a way forward would also be a way of involving local children in developing the solution.

It was also notable that SSCB undertook a self-assessment in preparation for the diagnostic and the peer team found itself in agreement with all the major points of that self-assessment. This is commendable as the self-assessment demonstrated a good self-awareness of the value of the work done and also identified areas where the SSCB still knows that improvement is required. An outstanding feature of the diagnostic was the universal enthusiasm of all the people the team spoke to and their commitment to improve their services and collective working still further in order to improve opportunities and outcomes for children in Sandwell.

3. Quality Assurance and Performance Management

The SSCB is now presented with comprehensive and regular information within an agreed dataset. This performance data increasingly includes information regarding all agencies. All partners agreed that the information is a vast improvement from that previously provided (or not provided). Not surprisingly in view of the previous dearth of meaningful information there has been a tendency to now try to include too much information and many members of the Board felt that the information was in danger of 'swamping

them' and this was also the view of the peer team. It is now time to refine this information and ensure that it provides a clear and focussed message to enable improved analysis, monitoring and challenge. It is understood that the SSCB through the Quality of Practice and Performance (QPP) sub-group is aware of this. Further revisions will take account of the outcomes from a regional project on performance information which is being funded by DfE. The Board should also consider how best to link data to the Business Plan to help identify priorities and performance.

A significant piece of work has been the review and creation of a 'user-friendly' Quality Assurance Framework (QAF) introduced in 2015-16. The purpose of the QAF is to 'provide all partners within the SSCB with a framework to assess the performance of multi-agency safeguarding practice within Sandwell and the effectiveness of the SSCB itself'. The peer team found the QAF easy to understand, with a good range of qualitative and quantitative indicators and a structured means of implementation through each SSCB sub group. It is recognised by the SSCB that it does need to assure itself and evidence that the QAF is embedded across the partnership.

The creation of the current QAF was the work of the QPP sub-group. The QPP sub-group is a valuable forum which is starting to impact positively on practice drawing on its collaborative approach. The newly appointed Chair of QPP (since April 2016) is providing drive and the sub-group is examining the SSCB data set, further refinement of the QAF, Section 11 Audit, Section 175 Audit, reviewing the approach to multi-agency audits, their impact and dissemination of learning (see also section 4 and Appendix 1 regarding multi-agency audits), oversight of single agency audits, and a workforce survey.

Good progress has been made on a Section 11 Audit which was another specific requirement of the Ofsted inspection report. This exercise is helping to hold partners to account and a wide range of Scrutiny Panel meetings has taken place across the partnership following submissions. A full report was taken to SSCB in May 2016.

The peer team understands that the Joint Strategic Needs Assessment (JSNA) is being refreshed and that it will include more information on vulnerable children and young people including those at risk from CSE. This information could be used by SSCB in deciding future priorities. In addition as the CCG has identified reducing infant mortality as a priority, it might be appropriate for this to be included in the JSNA and also be a priority for the HWB

Despite the extensive improvement work of the SSCB it was not possible for the peer team to find a clear line between the SSCB and front line practice across all agencies. Obviously this also relates to the need to evidence impact of SSCB work mentioned in section 2 above. Allied to this is a need to take more advantage of the quality assurance role of Independent Reviewing Officers to help capture what is happening 'on the ground' and to improve service practice and learning as, again, this was not clearly evidenced.

4. Audit Validation

An Audit Validation exercise was undertaken. The purpose of this was to examine how SSCB uses multi-agency case audit to assess and improve the quality of practice, particularly emphasising a proper focus on the 'child's journey', reflective practice, and good joint working between the key agencies. The key questions explored were:

- How effective is the local multi-agency audit process in assessing the quality of practice including practice in early help?
- How well are audit reports used by SSCB and partners?
- What action is taken in response to audit reports?

A full report on this exercise is given in Appendix 1 but the following key points should be noted

- Overall the Audit Tool has lacked impact to date – and the SSCB has recognised this
- The audit tool used for the three QPP audits (the Cross Border Audit, the DV audit and the LAC audit) meets some of the essential elements in a good case audit template
- New members and Chair have given the QPP group more focus on learning and outcomes for children
- There is a commitment from partners in making the audit process a valuable learning tool for the SSCB to use in keeping children safe and identifying risk
- Acknowledgement from the QPP group that their focus will be on fewer cases, therefore quality rather than quantity
- The Audit Tool has been used to measure process rather than quality of practice and outcomes
- The compliance in completing the audit form varies greatly
- It is Children's Services led and not reflecting on multi-agency practice
- Good practice could be better identified in recommendations
- Audit reports and recommendations have missed some clear practice issues which have been picked up in the audit process
- There is little evidence from the reporting process and recommendations of learning being fed down the line to frontline teams and practitioners

You have recognised in your self-assessment that improvement is required and identified the specific issues which need to be addressed.

5. Compliance with Working Together 2015

The membership of SSCB is large and inclusive. It also receives high quality documentation including a comprehensive Annual Report that provides transparency of progress. The improvements in governance, challenge and business management mean that partners now value the work of the SSCB and consider it a good forum for 'bringing things together' and facilitating strategic discussions. Despite the commitment of partners many are experiencing difficulties in their own resource capacity and this is exacerbated by many of them serving more than one LSCB. This does mean that there is

inevitability a significant number of apologies at sub-groups. This could be eased through the comments made in section 2 regarding the need to streamline membership and sub-groups.

The Chairs of the various sub-groups also meet collectively in a Chairs Group which does aid co-ordination. The group is frequently referred to as an Executive but there is ambiguity as to whether this really is the intended role of the group and whether it actually functions as one. As recommended in section 2 this ambiguity should be resolved and, when doing this, the recommended principles in the Wood report should be taken into account.

Partners contributed to and agreed an honest self-assessment in preparation for the SSCB diagnostic. In discussions with partners it was evident that they shared and 'owned' this self-assessment – which also illustrates a good degree of shared self-awareness. However, some partners also expressed the view that they felt that there is not a full understanding of their roles and responsibilities. This is despite activities such as the programme of 'Walk the Floor' exercises whereby agencies visit each other and the Board should consider how to assist developing this understanding still further.

Partners demonstrated consistently a desire to work together and there are already many good examples of this in place. The multi-agency MASH is an obvious example but there are others, including good joint working on the development and implementation of the CSE action plan and working with the voluntary sector in the development of the Early Help strategy.

The Learning and Development sub-group has been effective in ensuring there is a now a clear learning strategy in place, with an emphasis on sharing lessons to be learned and engaging with all agencies. This includes initiatives such as Train the Trainer, Trainer Buddy System and a Multi Agency Tutor Pool. As such, there is a commitment from all agencies to provide resources for the delivery of training and ensuring expert knowledge and feedback is shared effectively with multi-agency training being well received.

The SSCB has also undertaken both a Section 11 (see also section 3 of this feedback letter) and Section 175 Audit to ensure that partners, including schools, are fulfilling their safeguarding responsibilities. There is a need to ensure that there is a full response rate to the Section 175 exercise. In addition some feedback was given that schools would welcome strengthened engagement around safeguarding in accordance with the principles of the Wood Report around the duty to co-operate, especially in terms of identifying early help for children and young people in education settings and to develop further the important role of schools in this work.

In addition to the main Board the sub-groups are performing valuable work. The work of the QPP sub-group and how partners are working together there has been highlighted in section 3. Another noteworthy piece of evidence is the work of the Health Forum and, in particular, this provides a valuable opportunity for the local health providers to discuss a common response to safeguarding across 'health'. Arrangements such as this help provide both discussion and co-ordination and are greatly helping the work of the SSCB and its direct impact on services.

There was evidence of good work being undertaken through the Child Death Overview Panel (CDOP) which includes action on safe sleeping based on the Lullaby Trust. There is a good understanding of the main risk areas and a passion to use information to prevent future deaths. The Child Death Review process currently sits within the CCG which operates a nurse led model. The Wood report proposes some changes in accountability at national level and in the geographical footprint of the CDOP arrangements. It is important that future arrangements recognise the importance of the multi-agency role of the CDOP and of the connection with the issues within the local community.

The SSCB has a web site but it has been identified by the SSCB that this requires review and work on this is well underway with the intention that it be launched by the time of the SSCB annual conference on 5 July 2016. The peer team were provided a link to the development site and were able to see how this work is progressing. The team felt that the new site is a significant improvement and stressed the need for it to include information/ links for parents and carers (e.g. PACE - Parents against Child Exploitation) and schools.

6. Key Safeguarding Risk Areas (CSE, Thresholds and Early Help)

The SSCB asked the peer team to examine in particular its work around CSE, Thresholds and Early Help

<u>CSE</u>

It is worth noting that the SSCB is participating in the national project with the Office of the Children's Commissioner and Sussex University to formally evaluate the 'See me, Hear me' framework. This has included the SSCB organising in conjunction with the University of Sussex a theory of change workshop to consider how to implement the framework.

The SSCB itself has developed a clear and comprehensive CSE Action Plan with timescales has been developed and which takes account of the findings of the external audit. There is a strategic Child Missing Operational Group (CMOG) which monitors this plan and which has a Missing Operational Group (MOG) and Young Person Sexual Exploitation sub-group reporting into it. The CMOG is a sub group of the full board and provides data relating to the most at risk young people in Sandwell, so the board can monitor plans in reducing these risks and keeping young people safe.

Quarterly reporting takes place and an assurance report on missing children was presented to the Board in May 2016. Improvement work in developing the risk data collected and shared is underway so timely interventions can be planned and risk plans developed. The SSCB has recognised that it needs to ensure that other forms of exploitation are not missed whilst acknowledging the impact of CSE in the area. In addition missing/ return interview data needs improvement and more analysis of themes to inform risk assessments with more up to date data being available to inform MASE decision-making and protection plans.

There is good partnership involvement in Multi Agency Sexual Exploitation (MASE) including identifying risk and responding in keeping children safe. The SSCB has provided challenge to agency's participation in MASE which has produced good results. The current approach by SSCB has encouraged an evidential response to risk around CSE and continued learning. Again the external audit provided a good baseline for developing the SSCB response to CSE risks and keeping young people safe. Work in this area could be supported through themed audits to add to learning around good practice in response to CSE risks. The SSCB should also ensure that it keeps an overview of partnership awareness events to help identify gaps and avoid duplication by major partners such as Health and Schools.

Escalation of risk areas to the SSCB is made through the reporting from CMOG with the expectation that the board will challenge partners on the speed of their response. Police data is one area identified through CMOG in reporting to the board last year which is still outstanding.

Thresholds

The Ofsted inspection report stated that the SSCB should 'scrutinise the understanding and application by partner agencies of the LSCB threshold document in order that all children and young people are receiving services appropriate to their needs'. In response to this the SSCB commissioned an external audit of Thresholds and has created a refreshed threshold document. This was examined by the peer team and found to be clear and appropriate.

This refreshed document has been the subject of multi-agency training and there is a greater understanding of thresholds including step – up and step – down of cases between Social Care and targeted Early Help.

Although this work is commendable the SSCB is aware that Thresholds will need constant attention and multi-agency discussion to ensure they are still appropriate, understood by all partners and applied rigorously and consistently. This should include ensuring that Board members are taking the responsibility for their services in using the Multi Agency Threshold Strategy in their interventions with families and identifying the Lead Professional.

Early Help

Community Operating Groups (COGS) have been developed to provide Early Help. As part of this service the COGs include a social worker to advise on assessments and appropriate support for families. The SSCB has been instrumental in challenging partners around the Lead Professional role and ensuring the right service leads on this. Performance reports are presented to the Prevention and Early Help Board which in turn presents to the Safeguarding Board, although it would be helpful if partners develop their own performance data in relation to Early Help so they are fully accountable when presenting to the SSCB and able to challenge performance data which is collected by the QA team. This should include Performance data that demonstrates the impact of the different levels of Early Help and how they are responding to the Lead Professional role.

In addition the Team Around the Family (TAF) plan has been reviewed to reflect the Signs of Safety methodology, with all professionals receiving training on how to identify positives and what needs changing for families

LEAN Reviews of MASH processes bring together the role of the early help desk and MASH 'Front Door' to enable to screen referrals so families receive the appropriate service and at the right level of need.

Again this is an area where themed audits would be useful, especially around Early Help cases to ensure that they are in the right level of service to deal with the presenting risks.

7. Information Health Check

Prior to the diagnostic, a desktop evaluation was carried out to provide an information health check on what is required from the SSCB in Annex A of the Framework and Evaluation Schedule for the inspection of services for children in need of help and protection, children looked after and care leavers.

The main findings were that the requirements of Annex A are met and the following specific points were noted:

Strengths

- The documentation is clearly presented so that it is easy to see what the SSCB members are being asked to do and whether it has been achieved. There is an open approach to strengths and areas for improvement and generally documents are written in a clear and concise style
- The improvement journey is evidenced as is the fact that the SSCB has had to do a great deal in a very short space of time
- Evidence is given of considerable commitment from key partners in sub-groups/ chairs groups etc. in supporting the achievement of SSCB and its statutory responsibilities. This also extends to other partnerships including a joint session with the Local Safeguarding Adults Board
- Two Serious Case Reviews completed (one cross border) and published and evidence of an informed dialogue with the National Panel
- The Independent Chair is very visible in documents (including photos in the newsletter and presentations) and in setting out aspirations/expectations

Areas for Development

- Timescales and action owners in minutes need to be recorded and followed up/carried forward
- Agree accountability for response and actions as outlined in the Licensing Act 2003
- Voice of the child informing practice - the SHAPE scheme and takeover day are only recent. Signs of Safety provides a good model for gathering the child's voice but was only launched in autumn 2015.

- Diversity - there was a proposal to set up a Faith and Culture sub group which was replaced by a different model using a task and finish group, chaired by the LADO, which is supplemented by work through existing groups. 'The peer team considers that the Board's activity on diversity needs to be brought together into a single, coherent plan'.
- Senior level accountability going forward - this is particularly important in view of the Wood report and ensuring that there is strategic sign up. The document suggests that the 'Executive' is not a group of senior leaders but a meeting of sub group chairs
- Developing a process for recording and acting on areas of challenge and risk
- Embedding the learning from the SCR s over time and also any lessons from the Domestic Homicide reviews which have been published in Sandwell.

8. Recommendations

We would recommend that the Board:

- Review and streamline its structure (membership of the Board and number of sub-groups) including clarifying the role of the Chairs group in the context of the Wood Report
- Prioritise learning from its own audits to influence work on the multi-agency front line
- Continue to ensure that the Learning and Improvement Framework is active and includes external audits, serious case reviews, CDOP, service feedback and the reporting framework
- Increase the pace of progress with Faith, emerging communities and acting on the Voice of the Child
- Ensure full ownership of the Business Plan by increasing involvement in its preparation
- Refine performance data/ information to increase clarity and focus
- Ensure key Board partners are clear in what they see as the role of the new Chair, are involved in the process and appoint accordingly

Through this letter we have sought to outline the strengths of the SSCB 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. For further improvement support you can contact the LGA's Principal Adviser for the West Midlands, Helen Murray, who can be contacted by either email: helen.murray@local.gov.uk or by phone on 07884 312235.

In addition, your regional LGA Children's Improvement Adviser is Claire Burgess who can be contacted by either email: claire.burgess23@gmail.com or by phone on 07854 407337.

Once again, thank you for inviting us to undertake a peer diagnostic and to all involved for their participation.

Yours sincerely

Peter Rentell
Programme Manager (Children's Services)
Local Government Association
On behalf of the peer diagnostic team

Appendix 1 – Audit Validation Report

1. Introduction:

The Peer Diagnostic includes an Audit Validation exercise to look at:

1. The case audit framework and how effective it is in assessing the quality of practice.
2. The case audit reports that are received by management.
3. The action taken in response to case audit reports.

The findings in this report are based on gathering evidence through a number of routes:

- Meeting with the Quality of Practice and Performance subgroup and its chair to discuss Sandwell's audit processes and structure, particularly considering the On-Line Case File Audit Guidance. This is the tool that is used to audit all open and closed cases across the Local Authority,
- Review of six cases files on ICS and review of the audits completed in relation to the cases.
- Two focus groups in relation to the themed audits which included managers and key partners of the Quality of Practice and Performance subgroup.
- Policies and procedures to support the on-line file audit process.

2. The Case Audit Framework

The Quality of Practice and Performance Sub - group (QPP) of the SSCB has developed an audit tool over the last 18 months which has been used to undertake three themed audits. This sits alongside three commissioned audits completed by external auditors on CSE, Early Help and Thresholds to inform the Board on the current performance in relation to practice standards and keeping children safe. The On-Line Case File Audit procedure has been operational for just over 18 months, and is sent to the members of the QPP to complete four weeks in advance of the planned meeting to grade each case. It is a peer audit, making use of technology to circulate to partners and complete on-line. It is in the process of refinement and was updated recently to complete a themed audit on neglect. Most partners within the QPP have welcomed the changes with more focus on outcomes, practice and keeping children safe.

A good case audit template should include the essential elements outlined in the table below. The comments next to each element reflect the extent to which the SSCB case audit framework examines these aspects of practice, and how accurate the completed template proved to be in the sample of six cases. There was open acknowledgement by managers spoken to that the ICS system in use at Sandwell was not efficient and that a new system had been commissioned with an implementation date of before the end of the year.

Practice Area	Covered by the case audit template	Comment
Basic information	Yes	The multi-agency audit tool used for the three themed case audits contained a section around demographics. There was clear guidance on what is required, which is less so in the new audit tool designed for the Neglect audit
Effectiveness of current and previous interventions	Yes	The audit tool contains a section on record of involvement with a sub-section on effectiveness in keeping the child safe and promoting the child's welfare. However, from the six cases audited there was mixed responses from the agencies involved in the audit with often just a Yes/ No response
Assessment of need and analysis- have risk and protective factors been considered	Partial	The case audit template checks if assessments have been completed in the last year, if risks have been analysed, quality of assessment and management oversight. This section was usually completed with useful information/ evidence by Social Care but less so by partner agencies. Recording was good on the case notes themselves in all cases but the lack of chronologies made the analysis very difficult particularly for audit purposes. This would have identified in one case that the children should have gone to a CP conference sooner, but was not picked up in the audit. In another case there was concern about assessment of risk and decision making in relation to this, and lack of management oversight was picked up in the audit. The audit tool encourages yes/ no responses and although a comments box is available in each section, this was not appropriately utilized by all the QPP partners. In one particular case the police had no responses yet the case had gone to conference and they had been involved

Service Response	Partial	This area is explicitly addressed in the audit tool, and dealt with by all auditors although again the degree of response was difficult to judge. Three of the cases audited focussed specifically on issues in relation to the delay in holding a receiving in case conference. One case should have gone to court proceedings earlier but this was not addressed. The audit tool has separate sections for CIN; CP; Care Planning for CLA and a Review section. All the sections address process issues, but also ask about the child and family involvement and evidence of interventions that made a difference. The child's plan was found on three cases, it could not be found on two cases and it appears on one it appears that the court proceedings ended without an agreed permanency plan. The quality of the CP plans was not addressed and this area seemed to be viewed in a process orientated way. There is a question on the plan being SMART but little evidence in the response on the quality
Building a trusted and effective relationship	Yes	Questions about the wishes and feelings of the child and family are asked in the audit and questions about the service user involvement are threaded through the various assessment and plan sections. From the recordings and focus groups, it was evident that the workers had developed very positive working relationships with families, and used a range of tools to engage the children. This was not always picked up in the audit responses.
A child centred approach including attention to equality and diversity	No	The audit tool does not address this area, apart from the section on case details asking the child's ethnicity. The audit process is particularly weak on issues of equality and diversity and there is little qualitative prompting around the issue. One family had a dual heritage, but specific comments about that or how those needs were being met were not be found. This did not come through on the discussions with the focus groups or from the QPP sub-groups in our meetings.

Multi – agency involvement	Partial	There are questions about communication with referrers, and the multi – agency section asks about evidence of multi – agency approach, with a query about which agencies are involved in certain meetings. There is no real evidence of it being addressed in terms of effectiveness and outcomes in the six cases
Management, supervision and oversight of practice	Partial	The audit tool has just one question on this area and does not address reflective practice or the effectiveness of management oversight in outcomes for children. Supervision was found on all six cases but was limited in scope and was very frequently process driven. From case files it was not always clear why the case had moved in a certain direction and plans were not referred back to or changed. Certainly in the one LAC case audited the review had little input from partner agencies on the planning for the child. The managers focus group and IRO's seemed much clearer on practice planning and the need to improve in this area.
Quality of case recording	No	The challenge process around the QPP peer audits needs to be considered, particularly around disagreement on grading cases from partners on the case notes.
Process monitoring	Yes	The audit tool does cover organisational processes on each agency an dhow this fits into the overall planning for the child. Further analysis is needed on the journey for the child in terms of when interventions are needed and begun

The audit tool was only really completed by partner agencies in the QPP subgroup as a tick box exercise and the number of cases did not help this process. The QPP group, with a new chair and new members have recognised its limitations and recently designed an audit tool to focus more on impact and outcomes for children and families. This should produce more 'buy-in' from partners into the effectiveness and impact of audits.

3. Reports received by management.

All three management reports to the SSCB from the audits on Domestic Abuse, Compliance with West Midlands Cross Border Protocol and Effective Support and Interventions for Looked After Children were reviewed. Each report gives an introduction to why this particular theme was audited, the scope and the purpose and methodology used. The reports contain the grading's given to each case and a summary of the overall findings which leads to a summary of recommendations and an action plan on two of the audits undertaken - the LAC audit has yet to produce an action plan.

The findings in the reports are very limited and specific to a particular focus. Their usefulness to the SSCB is limited due to this and miss a great deal of other information which would produce a clearer picture on practice and performance. One clear area they miss is the good practice identified in the cases audited which clearly would be useful for training and improvements. There is little focus on outcomes or impact on keeping children safe and the lack of impact has made compliance by partners in the audit process less productive.

A list of all planned themed audits was supplied although they do appear to be very relevant to the practice issues in Sandwell.

4. Actions taken in response to case audit reports – what do management do with the information.

This is a particularly weak area for the QPP and SSCB to demonstrate impact and performance in improving practice in keeping children safe. It is clear from the focus group with the QPP that this has been recognised and plans are in place to address this area. Managers are reporting little impact from themed internal audits so far and as there was no focus group with practitioners undertaken during the audit validation it is difficult to assess this.

Any cases graded inadequate/critical are taken up the management line by the Performance and Quality Assurance Group Leader and monitored until the case is resolved.

5. Main Messages

Key messages and themes for follow up:

- The audit tool used for the three QPP reviewed, the Cross Border Audit, the DA Audit and the LAC Audit does meet many of the essential elements in a good case audit template. However, from the evidence seen so far it is used to measure process rather than quality of practice and outcomes. The compliance from other agencies in completing the audit form does vary greatly and I this may be due to agencies not believing or experiencing the value from it. It seems very much to be Children's services led and not reflecting on practice

- The auditing process has had a focus on quantity rather than quality with a high number of cases being sent to agencies to audit which has taken a great deal of time and evidence so far seems to suggest produced little insight into practice and impact
- Audit reports and recommendations have missed some clear practice issues which have been picked up in the audit process but are outside the main remit of the audit. This also extends to good practice and interventions also not forming the learning from the audits
- There is little evidence from the reporting process and recommendations of learning being fed down the line to frontline teams and practitioners
- The new chair of the QPP group since the beginning of April has identified the lack of impact the current audit tool has produced on actually measuring practice and what is working well and what areas need improving. The Neglect audit which should have taken place in May and discussed at May's QPP meeting was abandoned and instead the group re-designed the audit tool. The focus QPP group felt this was a very productive exercise and that it could produce some real evidence on what is happening at the frontline across all services
- The QPP and SSCB have identified and agreed that while the whole themed peer auditing process is essential, up to now has produced little evidence and impact, and that the future journey is the focus on what the audits are saying as regards practice.