Northumberland County Council

Appendix 2

Your Ref:
Our Ref: SD/JA/13/01
Enquiries to: Steve Day
Direct Line: 01670 624037
Fax: 01670 626134
E-mail: Steve.Day@northumberland.gcsx.gov.uk

Date: 30th January 2014

Dear Jane,

Re: Critical Friend Review.

This letter summarises the findings of the critical friend review undertaken by Northumberland which took place on 21-23 January 2014. I would like to take this opportunity to thank you and your staff for their assistance in undertaking this task. We were struck particularly by their honesty and openness throughout the process as well as their willingness to engage productively during interviews.

The review aimed to provide an objective evaluation of the key lines of enquiry (KLOE) and hypotheses identified by your senior management team which were summarised within your presentation to the review team as:

1. CP referrals to Strategy Meetings.

Hypothesis-Children are sticking in the CiN system possibly because of the effectiveness of support with a tendency to escalate referrals as a CP concern. This might suggest a risk averse culture amongst CESC and partner agencies.

2. Strategy Meeting to section 47.

Hypothesis- The decision making at Strategy Meetings is not robust and a risk averse culture amongst CESC and partner agencies may result in a default outcome as a section 47.

3. Section 47 to ICPC.

Hypothesis-The high rate of ICPCs is due to the quality of risk assessment and a risk averse culture amongst CESC and partner agencies.

4. ICPC to CPP

Hypothesis-A high number of ICPCs result in a CPP and this may be due to a lack of challenge from the Reviewing Officer and /or further evidence of a risk averse culture amongst CESC and partner agencies. The CPP's are not always SMART or understandable to partners and families.

In order to conduct this review the team read and evaluated the key documents sent to us prior to the site visit, interviewed a number of key staff whilst on site and triangulated their views. A number of audits were undertaken based on the KLOE, two RCPC and two Strategy meetings were also observed. An evidence base was established through this process from which our recommendations for further development emerged. The team fed back the findings of the review which included recommendations to the senior leadership team on 23rd January 2014.

The following outline the key findings:

Strengths

- We found throughout the interviews with staff a committed and motivated workforce who understood their role and function.

- Without exception staff spoke highly of Stockton and articulated positive feelings about working for the authority. Some staff who had worked elsewhere spoke favourably about Stockton in comparison to their other employment experiences.

- Similarly staff spoke of very good management support and a discernible improvement in this area over the last 12 months

- Staff are positive about the anticipated changes following the single assessment and are positive about the 1st contact team especially the presence of a social worker in the triage process.

- Duty workers indicated their workloads are manageable.

- All staff interviewed indicated a willingness to improve practice and appeared to exhibit a good level self-awareness.

- Social workers were particularly complimentary about the training in direct work with children.

Hypotheses

1. ***Hypothesis-Children are sticking in the CiN system possibly because of the effectiveness of support with a tendency to escalate referrals as a CP concern. This might suggest a risk averse culture amongst CESC and partner agencies***.

Process time Period: CP referral to strategy meeting

- From the audits and interviews, CP referrals to strategy discussions seemed appropriate, but there is evidence that opportunities for social care interventions at an earlier stage were missed which resulted in the case coming back with a heightened level of risk.

➢ CIN Sticking in the system

- From the ICPC audits completed there is evidence that a good number of cases had been CIN cases for some considerable time and that some of the cases should have been subject to an ICPC at an earlier stage.

- From discussions with other agencies it is possible that CIN cases don't appear to be actively progressed by CESC and, significantly, partners articulated a lack of confidence in the CIN framework.

- The fieldwork social work teams appear to be focussing on CP cases possibly to the detriment of their CIN cases.

- Anecdotal evidence suggests there may be a reluctance to agree for CP plans to be 'deplanned' because of an anxiety that the momentum of intervention, planning and review would be lost and the case would be allocated to an unqualified worker.

➢ Tendency to escalate referral as CP concerns

- We found no evidence that professionals are inappropriately escalating referrals up to a CP threshold. However there is a concern that there might be an unintended disincentive to refer appropriate cases because of the new requirement for referrals to have an accompanying CAF.

2. Hypothesis- The decision making at Strategy Meetings is not robust and a risk averse culture amongst CESC and partner agencies may result in a default outcome as a section 47.

Process time Period: Strategy to Section 47

➢ Decision making at Strategy Meeting is not robust

- We found evidence of a habitual use of strategy meetings as a forum for making decisions about what to do in CP investigations, including whether or not to convene an ICPC. We believe this to be inconsistent with procedure and is very likely to affect the attendance of agency representatives.

- There is evidence that a significant number of reconvened Strategy Meetings are not necessary and are used to complete the section 47 rather than decide if a section 47 is required and plan accordingly.

- From the evidence seen it appears that the Initial Assessment process isn't used to determine if a 47 is required. It seems that Strategy Meetings are convened upon receipt of the referral.

- There is compelling evidence that risk is not evaluated as part of Strategy Meetings and this coupled with the partner agencies views regarding the robustness of the CIN framework leads to an inevitable tendency for cases to go to section 47 and then onto an ICPC.

- There appears to be an overreliance on the ICPC process and CP process generally rather than a consideration of parallel ways of working for example, court processes. This appears to be a 'belt and braces' approach that means some children are subject to CP plans as well as to court orders.

3. ***Hypothesis-The high rate of ICPCs is due to the quality of risk assessment and risk averse culture amongst CESC and partner agencies.***

Process time Period: Section 47 to ICPC

- Quality of risk assessment

- The Section 47 template doesn't lend itself to a specific risk assessment and there is no space for the child's comments/views or those of the parents.

- We couldn't find any evidence that staff or partners have a common understanding of a risk assessment model/framework and there is a significant risk that this undermines the robustness of decision making throughout the CP process.

4. ***Hypothesis-A high number of ICPCs result in a CPP and this may be due to a lack of challenge from the Reviewing Officer and /or further evidence of a risk averse culture amongst CESC and partner agencies. The CPP's are not always SMART or understandable to partners and families.***

Process time Period: ICPC to CP plan

- Lack of Challenge at ICPCs

- In 9 out of 10 ICPC audits the threshold for a CP plan was more than met, although in some cases the categories appeared in our view to be incorrect.

- The multi-agency report is perceived as being the social work report which contains some information from other agencies. Our view is that the report is not a multi-agency report and should not be badged as such. The report is authorised by the Team Manager and this seriously undermines agency accountability.

- From the audits and 2 conferences observed there appears to be a lack of conference members evaluating risk, challenging each other, and agreeing the severity and likelihood of harm within the context of the information presented. The process appears to lack 'collaborative ownership' within a professionally healthy challenging culture. The challenging role of the Reviewing Officer, such as it is, appears to be limited to declaring a view about whether a CP plan is required or not rather than challenging views about risk which may or may not lead to a plan.

- Similarly, the 'multi-agency' report frequently did not make a recommendation regarding the need for a CP plan or the category. None of cases audited made any recommendations regarding the content of a plan. This means that the chair is responsible for assimilating the information, making a judgment, and deciding the plan. Again, as a process this is not collaborative and other agencies are not contributing to what should be a multi-agency decision. In our view a key function of the conference process is for each participant to have their professional biases challenged on the basis that policing one's own biases is notoriously difficult and dangerous.

- Team Managers do not attend ICPCs which means a crucial and influential professional is not present to contribute to the risk assessment or decision making process.

- Outline CP plans made at conference appear to be overarching, often vague, and not outcome focussed. The Core group appears to develop this but the ones we saw did not always reflect the original outline plan made by the ICPC. Again these were often vague, and are unclear about desired outcomes. In the cases we audited, there appeared to be two CP plans in existence. We understand that we have seen the old style CPP and a new template is now in use.

Recommendations

- The LSCB should consider undertaking a review of current CIN practice to ensure need is being appropriately assessed and plans progressed.

- The LSCB should review how Strategy meetings are being used specifically to ensure an agreed understanding about purpose and function which is procedurally compliant.

- The LSCB should identify and develop a risk assessment model and framework that is shared and understood amongst all LSCB partners to be used in Early Assessments, Section 17 Child in Need processes, Section 47 Child Protection Investigations, Strategy Meetings and Child Protection Conference processes.

- CESC should consider, for a time limited period, Service Managers assuming the responsibility for deciding if an ICPC should be convened. This may help to establish consistency and helping to identify alternative processes.

- Team Managers should attend ICPCs and chair the first core group meeting.

- The LSCB should consider requiring separate conference reports from partner agencies that are signed off by the appropriate agency manager and include an analysis of risk with suggested recommendations.

- The Strategy Meeting, ICPC and RCPC agenda's should include a section where a multi-agency discussion takes place '***that identifies the number, severity and duration of risk indicators balanced with mitigating strengths/resources and benefits that results in an informed judgement about the severity of harm, the likelihood of, and the severity of, future harm occurring/recurring and the anticipated impact on the child'*** (taken from the regional assessment framework).

- The LSCB should urgently develop a single CP plan template that is easily understood, actions are attributed, it is clear about timescales and states how outcomes for the child will improve. It should also contain clarity about expectations of the family and Core group members and contingency planning.

- CESC and the LSCB should consider developing the role of the Reviewing Service further as a key Quality Assurance service that has an independent check and balance function.

- The LSCB should consider reviewing and re-launching the continuum of need document training to ensure multi-agency knowledge of its existence and the agreed thresholds.

- The LSCB should consider developing an audit template and establish an auditing schedule for ICPCs and RCPC's. The purpose is to reassure the LSCB that the

process is rigorous in assessing and evaluating risk, that CPP's and decisions are robust and the standard of reports, attendance, and so forth are appropriate.

I hope the above evaluation against the KLOE and the outlined areas of strength and subsequent recommendations are helpful.

Yours sincerely

Steve Day
Safeguarding Standards Manager & Principal Social Worker