SAFEGUARDING CHILDREN IN WIRRAL

SCRUTINY REVIEW

"Safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play".

A report produced by
THE FAMILIES AND WELLBEING
POLICY & PERFORMANCE COMMITTEE

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FINAL REPORT

WIRRAL BOROUGH COUNCIL

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1. INTRODUCTION

At the meeting of the Families and Wellbeing Policy & Performance Committee, held on 28th January 2014, Members agreed to undertake a Scrutiny Review to investigate the adequacy of safeguarding procedures for children in Wirral. As a result, a Scrutiny Panel comprising five Members has held a range of meetings in order to obtain appropriate evidence.

An Executive Summary of the findings follows, together with the recommendations arising from this Review. The Report then sets out the background to the original brief, as well as the methodology adopted for gathering the evidence. This is followed by the main body of the Report which provides contextual information and details the key findings of the Review along with the evidence gathered in support of the recommendations proposed by the Scrutiny Panel Members.

2. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Why was this scrutiny review undertaken?
This topic was selected for further scrutiny in order to give members the opportunity to assure themselves that the Council and partners have adequate safeguarding mechanisms in place and that those processes work in practice.

National and Local Context:
The recent high profile events in Rotherham, Rochdale and Oxford, among other towns, have brought the issue of child sexual exploitation, and the safeguarding of children in general, to national prominence. Underscored by other high profile cases, such as the Jimmy Saville revelations, child safeguarding has become more widely reported in the national media. Subsequent reports, such as those produced by Professor Alexis Jay and Louise Casey, have given safeguarding issues a prominence hitherto seen.

The demand for services from social care professionals is high. The report, Characteristics of Children in Need in England 2014 to 2015, recently published by the Department of Education, showed that, in England, 391,000 are assessed as children in need as at 31st March 2015. Of those, 49,700 were subject to a child protection plan at the same date. The equivalent figures for Wirral were 2,882 and 233. In comparison to the average for England, statistical neighbours and the North West region, Wirral has higher rates for each of the following categories: children in need, children on a child protection plan and looked after children.

Overview:
Members heard much reassurance during the review that appropriate procedures are in place to enable practitioners to undertake their safeguarding duties effectively; representatives from many agencies expressing confidence that processes were robust enough. However, during the review the members met with a small number of families who had experience of the social care system. In particular, one of those case studies relating to potential child sexual exploitation provided much cause for thought. The family member with whom the Members met provided an account which was troublesome. As a result, the Members questioned why trigger points for escalation had not been met and why more substantial action had not been taken earlier. Furthermore, the family member felt that she was not listened to, she felt isolated by services and that risks were not acted upon appropriately.

Perhaps, the concerns of the family member could have been addressed, to some extent, by better communication between agencies and that family member. That experience led the Members to conclude that, although there is confidence that policies and procedures are in place, the practical application requires all practitioners and managers to be on constant guard. The Members have concluded that it is not possible to say that “a Rochdale situation couldn’t happen here”. Some of the recommendations in this report flow from the experiences of the case studies.

From the perspective of social workers during a focus group, when asked whether Wirral was more dangerous for children than a number of years ago, two attendees indicated that it was; largely due to the increasing quantity and complexity of the workload. Four other attendees replied that it was now more safe, although it was pointed out that “the system is relying on the professionalism of social workers”.

The demand for services and organisational structure:
Members were informed that, in comparison to the average Local Authority, Wirral has a higher proportion of children requiring substantial levels of support, that is, those cases which have been escalated to Specialist services, requiring the intervention of a social worker. As the number of referrals to social care in Wirral is high, a larger volume of work is generated in the system.

Members were informed that, in the past, Wirral has been unusual in providing quick referral to social care, rather than to other services, lower in the spectrum of need. There has been an intention, within the local authority, to provide a greater degree of early intervention in order to stop an escalation to social care. Although some progress has been made in reducing the cases in Specialist Services, there is recognition among officers that further progress for appropriate stepping-down of cases is required and this is actively taking place.

The front door for children at risk of serious harm is the Central Advice and Duty Team (CADT), which is incorporated within the Multi Agency Safeguarding Hub (MASH), established in January 2014. A MASH co-locates a whole range of agencies, including police, local authority children's social care, education, and health staff, to share information and identify emerging problems early. Wirral was among the earlier Local Authorities in the country to adopt this model and is proving effective as a driver to improve communication and greater cooperation between agencies. The Members were impressed by the development of the MASH model and suggest that, in order to develop the model further, consideration should be given to the inclusion of a larger number of partner organisations.

The gateway for referral of children at a lower level on the spectrum of need to Targeted Services is also physically located within the MASH at Moreton. However, the Gateway team operates separately to the CADT. It is suggested by the Members that further consideration be given to other operating models for the front door to both Targeted and Specialist Services, in particular those options seeking further integration. This should enable more effective tracking and movement of children between the two service areas.

Concern was raised during the review regarding the ease with which performance data could be easily provided in order to effectively monitor the outcomes and the movement of children across both Specialist and Targeted service areas. Members propose that a more effective performance monitoring mechanism be established.

Procedures and processes:

During this review, the members have received reassurances from a significant number of managers and practitioners that adequate policies and procedures are in place to enable them to undertake their safeguarding duties effectively. However, it was acknowledged that a weakness in systems nationally is that either people will not give evidence or the evidence is not extrapolated effectively. There was also an understanding that the effectiveness of safeguarding mechanisms is only as good as the intelligence obtained.

There was recognition of the importance of the voice of the child being heard throughout the process, although there was also a realisation by some practitioners that more needed to be done to ensure that it happens in reality. Members felt it important that, both before and after a child protection conference, additional effort should be given to enable the appropriate space and time be afforded to individual family members, including the child, to provide confidential information.

The case studies provided evidence that the outcomes of meetings are not always fully appreciated by family members. Following the child protection conference, feedback to the family members should be unambiguous. It is, therefore, suggested that the outcomes of meetings should be formally recorded and the family notified in writing. It is also proposed that the opportunities for the feedback of experiences from family members and children be strengthened.

In recent years, there has been an increasing drive for extended family members to become foster parents through the process of Special Guardianship Orders (SGOs). Members heard mixed views regarding the benefits of these placements. However, evidence from the Department of Education suggests that long term support for Special Guardians is beneficial. It is, therefore, suggested that a process is put in place to ensure that, wherever possible, appropriate support is made available to these families.

Partnership working:
Strong leadership from all senior partners in local arrangements is essential to establishing an effective safeguarding system. In cases, elsewhere, when there have been failures to safeguard effectively, reviews have often highlighted the absence of leadership and lack of partnership working as significant contributory factors. It is important that all parts of the local system are working closely together with good communications and a good appreciation of each partner's role.

Information sharing is an essential part of good local safeguarding arrangements. National research and analysis has indicated that failure to share information has been a significant feature of poor outcomes for children. The introduction of Wirral MASH has ensured that information is now shared more effectively although the members heard that the biggest single problem for the MASH is the delay in receiving information, with the longest delays typically being experienced with schools. In order to support schools in their safeguarding role it is proposed that further work is done to help develop a stronger relationship between schools and social care. In addition, in order to avoid delays in information being reported by schools, it is suggested that the creation of a single specialist reference point for schools within the MASH model may be beneficial.

During the review, it was noted that there is a good relationship between the voluntary sector and social care. However, it was also reported that the options for training were limited for some partners in the voluntary sector, particularly some of the smaller organisations. It is, therefore, suggested that a process is developed to ensure that safeguarding training is made as accessible as possible, particularly to those smaller organisations.

The recent high profile events in Rotherham, Rochdale, Oxford and elsewhere, have brought the issue of child sexual exploitation to national prominence. Both national and local evidence suggested that specific training on the identification of those young people at risk of child sexual exploitation would be beneficial across the partnership, including the police.

Staffing issues:
Particularly during the early stages of the review, members detected considerable frustration among staff who had been informed that a re-structuring along with allied pay increases for social workers was being planned but not yet implemented. Subsequent to those scrutiny review meetings, localised pay increases and a re-structuring of Specialist Services has been implemented. However, in due course, Members propose that further scrutiny work takes place to establish the effectiveness of the structural changes.

During the review, the Members were informed that caseloads for an experienced social worker in Wirral are significantly higher than the national average. Members were told that there is significant pressure, particularly on those more experienced staff who are allocated complex cases. It was also reported that the volume of work and high caseloads has also contributed to a significant turnover of staff. This has resulted in the employment of a sizeable number of newly qualified staff. Members, therefore, suggest that a process is put in place to reduce the caseload towards the national average. In addition, the provision of laptops or tablets would improve the ability of social workers to operate in a more flexible, agile and productive way. Although there will be a capital cost in providing new equipment, productivity gains would result in the longer-term.

Governance arrangements:
Local safeguarding arrangements are based on a national framework outlined in legislation and statutory guidance. Central to these arrangements are the statutory responsibilities of the local authority and the Local Safeguarding Children Board (LSCB). During the review, Members visited a meeting of Wirral's Local Safeguarding Children Board, during which the robustness of the challenge was observed. Members heard complimentary comments particularly regarding the quality of training, delivered across agencies, provided by the LSCB. However, Members have also noted the significant number of bodies within the Council who have an interest in safeguarding matters. The possibility of duplication and overlap across these groups is, therefore, noted. As a result, it is proposed that a review of the specific roles relating to safeguarding issues is undertaken in order to avoid duplication but more importantly to ensure that the appropriate lines of accountability are in place.

Both the reports produced in 2014 by Professor Jay and by the Communities and Local Government Select Committee highlight the failure of scrutiny and challenge within the system of governance at Rotherham. It was recommended by the Centre for Public Scrutiny that learning from the scrutiny process in Rotherham will be of benefit to scrutiny committees in all Local Authorities. In some other authorities, a protocol has been developed between the LSCB and the scrutiny committee. This can help manage expectations and priorities and assist the LSCB in understanding the role of scrutiny and the types of evidence and information that the scrutiny committee will need. It is proposed that consideration is given to the development of such a protocol in Wirral.

In considering the evidence found during the Review, the Panel Members have formulated the recommendations identified on pages 8 to 10.

RECOMMENDATIONS

Organisational structure *(Reference Section 7.1)*

Recommendation 1 – Development of the Multi Agency Safeguarding Hub (MASH)
Progress made towards the establishment of the Multi Agency Safeguarding Hub (MASH) is welcomed. In order to further improve the communication and sharing of information between partners, the Director of Children Services is requested to continue to develop the MASH concept and explore opportunities to include additional partner organisations in the model.

Recommendation 2 – The front-door to social care
The Director of Children Services is requested to consider alternative operating models for the front door to Specialist and Targeted Services including those offering further integration, such as a combined Gateway and CADT (Central Advice and Duty Team).

Recommendation 3 – Monitoring performance data
The Director of Children Services is requested to establish an effective mechanism to monitor the progress of children across different service provision and to provide regular performance data to monitor outcomes for young people and families who receive specialist or targeted services.

Procedures and processes*(Reference Section 7.2)*

Recommendation 4 – Contact with individual family members
The Director of Children Services is requested to ensure that opportunities are provided for individual family members, including the child, to provide information before and after a child protection conference.

Recommendation 5 – Formal notification to family members
The Director of Children Services is requested to ensure that the outcome of a child protection conference is reported to family members in a written format stating clearly the next steps which will follow and consider making available the opportunity for individual family members to discuss the outcome with a neutral contact.

Recommendation 6 – Feedback from service users
The Director of Children Services is requested to investigate the possibility of providing a mechanism for individuals to feedback experiences of the child protection conference process on a confidential basis, for example, by the use of a confidential phone number.

Recommendation 7 – 'Closing the loop'
The Director of Children Services is requested to consider the options for ensuring that the originator of a safeguarding concern is informed of the outcome.

Recommendation 8 – Definition of assessment threshold levels
In order to address concerns relating to the understanding of thresholds among agencies and partners, the Director of Children Services (or LSCB) is requested to develop a training plan aimed at reinforcing the interpretation and application of the definition of the threshold levels for intervention. The training will equip responsible persons with the skills to identify levels of risk and take appropriate action.

Recommendation 9 – Special Guardianship Orders
The Director of Children Services is requested to ensure that the processes in place to find Special Guardians are as robust as those for Foster Carers and Adopters so that all children placed under Special Guardianship Orders remain safe and are supported within that placement.

Partnership Working*(Reference Section 7.3)*

Recommendation 10 – Involving all partners in social work assessments
The Director of Children Services is requested to ensure that all organisations involved with the child, including third sector organisations, are given the opportunity to provide information when social work assessments are being prepared.

Recommendation 11 – GPs and safeguarding
The Director of Children Services is requested to work in conjunction with Wirral Clinical Commissioning Group to develop a mechanism to encourage GPs to provide relevant information to safeguarding investigations and formal meetings. This mechanism could include a training programme for GPs to enable a better understanding of thresholds for intervention.

Recommendation 12 – Relationship between schools and MASH
In order to make it easier for schools to engage with safeguarding processes, the Director of Children Services is requested to consider the provision of a reference point for schools within the MASH.

Recommendation 13 – Relationship between social care and schools
The Director of Children Services is requested to consider ways in which stronger relationships can be developed between social workers and schools, in order to encourage all schools to become more integrated in the safeguarding process.

Recommendation 14 – Access to safeguarding training
The Director of Children Services is requested to develop a process to ensure that safeguarding training becomes more accessible especially to small organisations in the third sector.

Recommendation 15 – Child sexual exploitation training for front-line staff
The Director of Children Services is requested to continue to encourage the uptake of additional training opportunities for front-line staff, including the police, regarding child sexual exploitation.

Staffing Issues*(Reference Section 7.4)*

Recommendation 16 – Social Care re-organisation: Follow-up investigation by members
The Strategic Director of Transformation and Resources is requested to enable scrutiny members to arrange a follow-up session / workshop to evaluate the effectiveness of the re-organisation once the new Specialist services social care teams are embedded. The review, which will include front-line staff and possibly parents and families, will also monitor the success of the plans to achieve improved retention of staff.

Recommendation 17 – Social worker caseloads
The Director of Children Services is requested to develop a mechanism to monitor the caseloads of social workers with the aim of reducing the caseload to, at most, the national average.

Recommendation 18 – Social worker support
The Director of Children Services is requested to consider the options for increasing the availability of laptops for staff, such as social workers, who are regularly working off-site.

Governance Arrangements *(Reference Section 7.5)*

Recommendation 19 – Governance arrangements
The Strategic Director for Families and Wellbeing is requested to undertake a review of the governance arrangements relating to safeguarding to ensure that remits of bodies, such as Children's Trust Board, Corporate Parenting Group, Health & Wellbeing Board, Local Safeguarding Children Board (LSCB), Safeguarding Reference Group and scrutiny, are clearly understood, the appropriate reporting lines are in place and that duplication of activity is avoided.

Recommendation 20 – The role for scrutiny in safeguarding
The Strategic Director of Transformation and Resources is requested to further examine the role of scrutiny in the safeguarding process by establishing a protocol of understanding with the Local Safeguarding Children Board (LSCB).

3. MEMBERS OF THE SCRUTINY PANEL

Councillor Moira McLaughlin (Chair)

The More you know, the more you see" - This is the statement which highlights that it is everyone`s responsibility to recognise abuse and act on what they see.

Families and Wellbeing Policy and Performance Committee have carried out some very significant pieces of in depth scrutiny in the last few years. Not so long ago we asked the question: Could a Mid Staffordshire situation occur in Wirral? We then set ourselves the task of finding out.

When we started the safeguarding review we asked ourselves, and then those we interviewed as the review went on, could a Rochdale / Rotherham situation happen in Wirral?
Was it possible that the voices of children and young people could go unheard here?
Could a situation whereby they are disbelieved and treated as though they are the problem by those supposed to protect them exist in Wirral?

With that in mind, we had conversations and took evidence from a very wide range of people involved in safeguarding. Most felt that policies are robust and procedures are carried out rigorously, though recognised that policies and procedures are not the only requirement. It is important that people involved listen, understand, respond and communicate with others.

We spoke, also to some who had experience of the working of the procedures themselves and some told us a different story. They told us of their feelings of not being responded to, of not understanding what decisions had been made and not feeling supported.

This report is a thorough piece of work and as Chair of the panel I would like to sincerely thank those who undertake this duty of safeguarding for their work, and for giving their time to this enquiry. I would also like to thank the members of the panel for their hard work in putting the report together and of course to the absolutely dedicated work of Alan Veitch, the Committee`s scrutiny support officer.

So, could a Rochdale / Rotherham happen in Wirral?
No one with any knowledge of the complexities of the difficulties of protecting children and vulnerable people from the evil of others would answer "never". What I think most would say is "not if I can help it ".

Councillor Wendy Clements

This review has sought to examine the safeguarding provided on Wirral and to ensure that the voice of the child is heard. I know that Members and Officers all want to be sure that we are fulfilling our responsibility to the most vulnerable children in our society and I would like to express my thanks to everyone who took time to meet with us and answer our questions.

The Centre for Public Scrutiny wrote in 2014, "If scrutiny isn't fundamentally about the central issue of improving outcomes for people, there's no point to it. The only way that it can go about making that improvement happen is by understanding how services are really experienced on the ground, and challenging those responsible to review and improve." (What Rotherham and Mid Staffordshire tell us about scrutiny and where it's lacking, Sept 2014). As part of this review members have sought to follow that challenge by speaking to a range of people who provide and who are subject to safeguarding activity. This is not always comfortable but did cause us to look carefully at the information we were receiving and ask further questions. You will see the impact of that in several of the recommendations of the report.

I believe that as we work to improve scrutiny this is an aspect we will need to develop more and more, not only in reviews but also at formal committee meetings hearing from people who actually use the services we are scrutinising.

Councillor Cherry Povall

Councillor Denise Roberts

Councillor Jean Stapleton

This Scrutiny Panel was supported by:
Alan Veitch
Scrutiny Support Officer
0151 691 8564
alanveitch@wirral.gov.uk

4. BACKGROUND AND ORIGINAL BRIEF

Due to the high profile of safeguarding issues at a national level, Members of the Families and Wellbeing Policy & Performance Committee were seeking reassurance that appropriate policies and practices were in place in Wirral. Therefore, Members of the Committee agreed to undertake an in-depth Scrutiny Review to investigate the suitability of safeguarding procedures for children in Wirral. As a result, a Scrutiny Panel involving five Members has held a range of meetings in order to obtain appropriate evidence.

It had been agreed that the scrutiny review would give members the opportunity to assure themselves that the Council and partners have adequate safeguarding mechanisms in place and that those processes work in practice. Scrutiny would also help the partnership to understand what the experience of families is and what may need to change to improve outcomes in safeguarding.

The Scope Document for the Scrutiny Review is attached as Appendix 1 to this Report. The key issues for the review were:

- Agencies working with children need to understand and be effective in their contribution to protection plans.
- The child's voice should be at the heart of every plan they may be subject to.
- It is difficult for children and families to understand services and their relevance at each stage of involvement.
- There is a key role to be played by the Local Safeguarding Children Board (LSCB), having the ability to address these issues and it needs to be effective in doing so.

5. METHODOLOGY FOR THE REVIEW

The Panel has employed the following methods to gather evidence:

5.1 Meetings

A series of individual meetings has taken place at which the Scrutiny Panel Members could discuss relevant issues with the following:

- Introduction to safeguarding
  Deborah Gornik (Head of Targeted Services, Children & Young People, Wirral Borough Council)
  Emma Taylor (Head of Specialist services, Children & Young People, Wirral Borough Council)
  Simon Garner (Corporate Safeguarding Manager, Wirral Borough Council)
- Visit to MASH (Multi Agency Safeguarding Hub), Moreton
  Laura Beech (Manager, MASH)
  Simon Garner (Corporate Safeguarding Manager, Wirral Borough Council)
- Police and crime
  DCI Tracy Hayes (Merseyside Police)
  D/SGt Michelle Hogg (Merseyside Police)
  Rosie Goodwin (Assistant Chief Executive, East & West Merseyside Community Rehabilitation Company)
- Health
  Maggie Chessall (Named Midwife, Wirral University Teaching Hospital)
  Noel Murphy (Health Visitor, Wirral Community Trust)
  Martin Hackett (Named Nurse, Wirral Community Trust)
- Catch22
  Jaine Crompton (Family Intervention Manager – Wirral, Catch22)
  Cheryl Kennah (Lead family support worker for IFIP, Catch22)
  Simon Gunner (IFIP key worker in Seacombe, Catch22)
- Advocacy agencies
  Bev Morgan (CEO, Home-Start Wirral)
  Lauren Upton (Family Support Coordinator, Home-Start Wirral)
  Aileen Alexander (Barnados – Action with Young Carers Wirral)
  Paul Stubbs, Team Manager, Looked After Children, Barnados)
- Domestic violence
  Jill Barr (Manager, Family Safety Unit, Wirral Borough Council)
- Observe a meeting of the LSCB (Local Safeguarding Children Board)
  plus meeting with the Chair of the LSCB, Bernard Walker
- Focus group with social workers – Specialist Services
  Jarred Law
  Ben Hornby
  Declan Morris
  Nicola Bolger
  Josie Lee
  Kirsty Wilson
- Focus group with social workers – Targeted Services
  Elizabeth Hartley (Family Intervention)
  Jane Egan (Family Support)
  Sarah Harper (Children's Centres)
  Mike Clarke (Restorative Practice)
  Mark Newman (Youth & Play Service)

- Re-visit to MASH (Multi Agency Safeguarding Hub), Moreton
  Anna Moulsdale (Manager, MASH, Wirral Borough Council)
  Lynette Morgan (Practice Improvement Manager, Specialist services, Wirral Borough Council)
  Suzanne Cottrell (Local Authority Designated Officer – LADO, Wirral Borough Council)
  Vicki McKenna (Manager responsible for child sexual exploitation and missing from home services, Catch22)
- Independent Reviewing Officers (IROs) plus review of anonymised child protection plans
  Maureen O'Brien (Independent Reviewing Officer, Safeguarding Unit, CYPD)
  Yvonne Jama (Independent Reviewing Officer, Safeguarding Unit, CYPD)
- Observation by members of a child protection conference
- Meetings with families who have experience of the safeguarding process

5.2 Written Evidence

The Review was also informed by written evidence including committee reports, Government documents and briefing papers from officers.

6. NATIONAL AND LOCAL CONTEXT

6.1 What is Safeguarding?

Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area.The welfare of all children and young people in the local community must be a top priority for any local authority. Safeguarding ensures that children are kept as safe as possible by identifying their needs, views and any risks they face. Services, information and support can then be provided as required. Where children are likely to suffer harm, local authorities have clear duties to intervene through child protection processes.

Safeguarding and promoting the welfare of children is defined by the Department of Education statutory guidance, 'Working Together to Safeguard Children' as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best life chances.

The guidance states clearly:

> *"Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Everyone who comes into contact with children and families has a role to play".*

If the local authority identifies that there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, it will carry out an assessment under section 47 of the Children Act 1989 to determine if it needs to take steps to safeguard and promote the welfare of the child. If concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference should be convened within 15 working days.

Child abuse comes in many forms; from neglect to physical, online to sexual. At a national level, the numbers of children involved are substantial. Recent statistics[1] for 2014-2015 report that, in England, 391,000 are assessed as children in need (Wirral 2,882) as at 31st March 2015. Of those, 49,700 were subject to a child protection plan as at 31st March 2015 (Wirral 233), compared to 39,100 six years ago. There were 635,600 referrals to children's social care in the year ending 31 March 2015. A complex pattern of need and risk emerges from the data:

- Over 49% of children in need have experienced abuse or neglect in their care.
- 18% are described as in need due to family dysfunction.
- New concerns are emerging as understanding of sexual exploitation, online risks, bullying and teenage domestic violence grows.

[1] Department for Education, Characteristics of Children in Need in England 2014 to 2015

The following tables report comparative data and show that the rates for children in need, children on a child protection plan and looked after children are all higher for Wirral than for the England average. The implications of this high rate of activity for social care in Wirral are discussed later in the report.

Table 1: Rate of children in need per 10,000
Historical Comparison (2013-2015)

	2013	2014	2015
Wirral	417.70	396.10	426.30
North West	343.10	365.30	367.70
Statistical Neighbours	408.76	410.49	406.52
England	332.20	346.40	337.30

Source: Department of Education

Note: A child in need is one who has been assessed by children's social care to be in need of services. These services can include, for example, family support (to help keep together families experiencing difficulties), leaving care support (to help young people who have left local authority care), adoption support, or disabled children's services (including social care, education and health provision).

Table 2: Rate of children subject to a child protection plan per 10,000
Historical Comparison (2013-2015)

	2013	2014	2015
Wirral	39.80	43.00	34.50
North West	41.40	50.80	49.90
Statistical Neighbours	44.12	55.32	57.08
England	37.90	42.10	42.90

Source: Department of Education

Table 3: Rate of looked after children 10,000 aged under 18
Historical Comparison (2013-2015)

	2013	2014	2015
Wirral	98.00	99.00	100.00
North West	78.00	81.00	82.00
Statistical Neighbours	79.20	81.80	82.00
England	60.00	60.00	60.00

Source: Department of Education

7. EVIDENCE FOR THE RECOMMENDATIONS

7.1 The Demand for Services and Organisational Structure

Thresholds of need give practitioners a common understanding of need and eligibility for preventative and protective services. Practitioners can then assess need and priorities and respond appropriately. The Wirral Local Safeguarding Children Board Procedures Manual provides practitioners with advice regarding the threshold for services to children in need. Four thresholds of need on the Team Around the Child continuum have been developed:

- Level 1 - Universal Services
  These are children who make good overall progress in all areas of development. All children and young people are entitled to receive support from these services, which are available to everyone irrespective of their needs. This includes GP's, health visitors and school nurses, schools, Connexions (for age 13 plus), youth service, leisure and play facilities and housing.

- Level 2 – Preventative Services: Single Agency Response
  Some children require support beyond that provided by their families and universal services. Their life chances would be improved with effective, single agency support. Any practitioner working with a child or their family may identify, in the presentation or behaviour of a child, that they have additional needs, which could be met by a single agency or service.

- Level 3 – Preventative Services: Multi-agency response
  Some children will have more complex needs. Their life chances are likely to be improved by effective multi-agency support. If a practitioner believes that a multi-agency response may be required and appropriate consent has been given, the practitioner should complete a Common Assessment and arrange a Team Around the Child Meeting where a lead professional will be appointed. The process must be discussed with the child and/or their parent/carer and consent obtained. The progress of the assessment and the implementation of the plans will be considered at review where decisions regarding further agency involvement will be made. At this level a Social Worker will not be involved.

- Level 4 – Children at risk of serious harm
  Where a child is suffering or likely to suffer Significant Harm, or has experienced Significant Harm a referral must be made to Social Care without delay. The referral point is the Central Advice and Duty team (CADT).

Within the Children's Services organisation at Wirral Council, services provided to children at Level 2 and 3 will be done so via Targeted Services. Specialist Services will support those children deemed to be at Level 4. Members were informed that, in comparison to the average Local Authority, Wirral has a higher proportion of children requiring substantial levels of support, that is, those cases which have been escalated to Specialist services. As of the end of June 2015, there were 671 looked after children in the borough. As the number of referrals to social care in Wirral is high compared to statistical neighbours, a high volume of work is generated in the system.

Table 4: Rate of referrals to social care per 10,000 Historical Comparison (2013-2015)

	2013	2014	2015
Wirral	560.30	602.20	634.90
North West	619.70	687.60	616.80
Statistical Neighbours	588.03	662.67	566.25
England	520.70	573.00	548.30

Source: Department of Education

Members were informed that, in the past, Wirral has been unusual in providing quick referral to social care, rather than to other services, lower in the spectrum of need. It has long been the intention to provide a greater degree of early intervention in order to stop an escalation to social care; a major driver for change being the Munro Report, which advocated a balanced early intervention offer. In 2013, a North West Early Intervention Strategy was developed and has subsequently been adopted by Wirral. Other drivers for change included the Frank Field report 'The Foundation Years: Preventing Poor Children becoming Poor Adults' and the Graham Allen report, 'Early Intervention: The Next Steps'. Members were informed that the key to success is "to get in early and get out early". Although some progress has been made in reducing the cases in Specialist Services, there is recognition among officers that further progress for appropriate stepping-down of cases is required.

As previously stated, the front door for children at risk of serious harm (Level 4) is the Central Advice and Duty Team (CADT). The CADT is now based in Moreton, incorporated into the Multi Agency Safeguarding Hub (MASH), which was established in January 2014. A MASH co-locates a whole range of agencies, including police, local authority children's social care, education, and health staff, to share information and identify emerging problems early. The MASH approach was first introduced by Devon County Council and has since been adopted across other parts of the UK. Wirral was among the earlier Local Authorities in the country to adopt this model. If a child is in danger of significant harm, social care, police and other key partners come together to provide a coordinated response and to determine the best way to keep the child safe. Current participants in Wirral MASH include social care, police, health, family safety unit and, since May 2015, an educational social worker. Members have been impressed by the development of the MASH model. In the past, a recognised strength in Wirral has been the strong partnership working and positive working relationships. It is intended that the introduction of the MASH will further embed these strengths. The Members were informed by practitioners that closer partnership working, improved communication and sharing of information have been achieved enabling more effective and faster evidence gathering on individual cases. A quick response may reduce the likelihood of the use of child protection plans. An additional consequence of the creation of the MASH is that different partner organisations are involved in shared decision-making; less work being passed from one agency to another. Members were informed by practitioners:

> *"MASH enables us to make safe, better informed decisions"*
>
> *"The creation of MASH has led to more dialogue with other professionals".*
>
> *"The MASH has already provided a great improvement, enabling better communication and sharing of information".*
>
> *"The MASH has led to an improvement in information gathering and cases are now sifted more quickly".*

However, the MASH concept will be further enhanced by inclusion of additional partner agencies. Therefore, the Members encourage the Director of Children Services to continue to further develop the MASH model, exploring the possibility of involving additional partners such as CAMHS (Child & Adolescent Mental Health Service, probation, public health / drug and alcohol workers and the anti-social behavior team.

Recommendation 1 – Development of the Multi Agency Safeguarding Hub (MASH)
Progress made towards the establishment of the Multi Agency Safeguarding Hub (MASH) is welcomed. In order to further improve the communication and sharing of information between partners, the Director of Children Services is requested to continue to develop the MASH concept and explore opportunities to include additional partner organisations in the model.

As described above, practitioners assess the needs and priorities of individual children. For those determined to be in need of either single-agency or multi-agency preventative intervention, a referral is made to Targeted services. In September 2013, the Gateway to Targeted Preventative Services was launched. With the introduction of the new process, when a child is referred to the Gateway, the case is triaged and the child is pointed to the appropriate service. The aim is to wrap a coordinated and integrated package around the family, with the intensity of support reflecting the changing needs of the family depending on family circumstances. Family support services are modeled to better coordinate multi agency support through a single Lead Professional approach, providing a single point of contact for the family. This approach focuses on working with the whole family at a community level. Historically, there had been poor sharing of data between partners, with a family having to tell their story time and time again, often to different service providers, resulting in a waste of resources and not a big difference to the family's circumstances.

The Targeted Services Gateway is physically located at Moreton within the same offices as MASH. However, the Gateway team operates separately to the CADT which prioritise and allocate cases for Specialist Services (Level 4). In the attempt to safely reduce the volume of children referred for care, it had been recognised that there was a need to strengthen the front door processes. The Gateway process has resulted in a cultural change for staff as they are no longer directly referring into social care. During the review, members were told:

> *"There is a need to change the emphasis from 'phone social care' to 'phone the gateway'".*

It is suggested by the Members that further consideration be given to other operating models for the front door to both Targeted and Specialist Services, in particular those options seeking further integration. This should enable more effective tracking and movement of children between the two service areas. It is understood that other Local Authorities such as Staffordshire and Cheshire East have embarked on the implementation of such models. Indeed, greater integration of service delivery was called for too by an interviewee who said:

> *"It should be an aim for families to not feel the impact of the Council's structures. Therefore, families should not see different faces because they fit into a different part of the organisation".*

Recommendation 2 – The front-door to social care
The Director of Children Services is requested to consider alternative operating models for the front door to Specialist and Targeted Services including those offering further integration, such as a combined Gateway and CADT (Central Advice and Duty Team).

During the review, it was not easy for members to access data to determine the movement of children between Targeted and Specialist services and therefore to clarify whether the attempts to reduce the numbers of children requiring support from specialist services were indeed being effective. It is, therefore, proposed that regular performance data is developed in order to adequately monitor the outcomes for young people and families who receive Specialist or Targeted services.

Members were informed that:

> *"Although a good mechanism for allocating cases, the Gateway is not effective at collecting and assessing outcomes for children and their families".*

Recommendation 3 – Monitoring performance data
The Director of Children Services is requested to establish an effective mechanism to monitor the progress of children across different service provision and to provide regular performance data to monitor outcomes for young people and families who receive specialist or targeted services.

9.2 Procedures and processes

During this review, the members have received reassurances from a significant number of managers and practitioners that adequate policies and procedures are in place to enable them to undertake their safeguarding duties effectively. Those agencies involved in the review provided positive confirmation from their perspective. There was an acknowledgement that the Local Safeguarding Children Board (LSCB) plays an active lead role in developing protocols and policies which all partner organisations and practitioners are expected to follow.

One practitioner explained:

> *"If mum does not put the children first, we will. There is no hesitation in escalating cases if it is necessary".*

However, another practitioner reflected the concerns of the Members when saying:

> *"All the processes are in place but we are all individuals".*

It is important that the child's voice is at the heart of the process. A child-centred approach to safeguarding is strongly established by legislation with Local Authorities being required to give due regard to the wishes of the child when making decisions about services. The wishes and feelings of individual children should be clear in all stages of the child protection process including during assessments, planning and reviews. There should also be appropriate participation of children in meetings, conferences and other decision making forums.

It is recognised that Wirral Council has developed a number of initiatives designed to ensure that looked after children and young people have a voice and that their views are represented including:

- Wirral Children In Care Council, a long-established body, having a key role in designing and informing service delivery for looked after children;
- Wirral Young People's Panel being involved in the recruitment and selection process for social workers;
- Close links with Wirral Corporate Parenting Group, made up of Members, Chief Officers and Heads of Branch, ensuring that their voices are heard.

However, it is also essential that the voice of the child and of individual family members is heard throughout the assessment and planning process. Indeed, the Independent Reviewing Officer has a crucial role as they quality assure the care planning and review process for each child while ensuring that each child's wishes and feelings are given full consideration. Even though progress has been made, one practitioner informed the Members:

> *"Agencies have now woken up to the tools of voice of the child. Whether we hear the child is different. There is still work to do to action the voice of the child".*

An Initial Child Protection Conference must be convened when it is believed that a child is suffering or likely to suffer Significant Harm. The Initial Child Protection Conference brings together family members, the child (when appropriate), advocates and those professionals most involved with the child and family to share and assess information. The conference will formulate an agreed plan of management and services, with the child's safety and welfare as its paramount aim. Members were informed that it is important that there are no surprises for the parents at the child protection conference. Therefore, the social worker goes through the report with the parent 24 or 48 hours in advance of the meeting. The Chair also meets the parents 30 minutes in advance of the conference to describe the process and ensure that the parents have a voice. It is important that parents are supported and protected at conference, although some of the meetings can have a large number of attendees. It is not unusual to have more than ten attendees particularly if there are a number of children involved and they are attending different schools. Indeed, it is also often encouraged, where appropriate, to hold a Family Group Conference to encourage wider family support. Therefore, in particular, in the circumstances of highly attended conferences, it is possible that an individual family member will not feel able to make their views known. As a result, following feedback from service users, Members propose that appropriate space and time is provided for individuals, including the child, to provide information in a more informal context where appropriate prior to the conference.

Individuals should have sufficient opportunity to share the information they feel is relevant with a professional in a manner with which they feel comfortable while being given a clear understanding of policies and procedures relating to the sharing of that information during the conference.

Recommendation 4 – Contact with individual family members
The Director of Children Services is requested to ensure that opportunities are provided for individual family members, including the child, to provide information before and after a child protection conference.

Following the child protection conference, feedback to the family members should be unambiguous. Case studies made available to the members suggested that this is not always the case. It is, therefore, suggested that the outcomes of the meeting should be formally recorded and the family notified in writing. Further evidence suggested that it would also be beneficial if family members had the opportunity to discuss the outcome with a neutral contact.

Recommendation 5 – Formal notification to family members
The Director of Children Services is requested to ensure that the outcome of a child protection conference is reported to family members in a written format stating clearly the next steps which will follow and consider making available the opportunity for individual family members to discuss the outcome with a neutral contact.

It was also noted by the members that there is currently limited opportunity for families and children to formally feedback experiences on the whole process. This would provide a real opportunity for future processes to be strengthened from previous misunderstandings. During one of the meetings with families, the Members were informed:

"We want social services with compassion".

Whatever the rights and wrongs of particular circumstances, it would surely be constructive to ensure that voices such as that were heard as part of a feedback process.

Recommendation 6 – Feedback from service users
The Director of Children Services is requested to investigate the possibility of providing a mechanism for individuals to feedback experiences of the child protection conference process on a confidential basis, for example, by the use of a confidential phone number.

The Members were informed by practitioners that there is some frustration regarding the Gateway and CADT processes as cases can be referred in to the system but there is no feedback regarding the outcome. They were informed that the originator of the concern can be waiting for the results of the assessment when the case has already been closed. Clearly, this could result in the originator still having concerns, thinking that action was being taken but, in reality, no further action was being taken. To avoid this occurrence it is suggested that options are considered to ensure that the originator is always contacted to inform them of the outcome to the case, particularly when a case is to be closed.

Recommendation 7 – 'Closing the loop'
The Director of Children Services is requested to consider the options for ensuring that the originator of a safeguarding concern is informed of the outcome.

The threshold framework, developed by the LSCB and described earlier in Section 7.1 of this report defines Threshold Levels 1 to 4. However, the application of the thresholds is, to some extent, subjective. The same definition of Levels 1 to 4 is used across all agencies. However, the interpretation between agencies and social care may differ. As a consequence, there are genuine professional disagreements and differing opinions regarding particular cases.

> *"The consistency in application of thresholds is a real problem".*

> *"It appears that some agencies do operate with different thresholds".*

It was interesting to note that some practitioners felt that the application of thresholds across agencies had improved in recent times because dialogue between the agencies has developed since the implementation of MASH. However, during the meetings, other practitioners did express the concern that the threshold could be driven by resources and by what services a particular agency are able to offer. A small number of practitioners expressed the view that the threshold has been raised compared to the documentation.

> *"There is a perception that the threshold for intervention from social care has heightened due to a reduction in funding, reduced capacity and higher caseloads."*

In addition, the view was expressed that the level of understanding of thresholds among partners is not universal. This is demonstrated, according to some practitioners, by some partner organisations appearing to lack the confidence to take full responsibility and accountability for taking safeguarding action themselves. As a result, there was a perception that referrals to social care can be seen as an easy option and a way of diverting the problem elsewhere. Therefore, in order to help agencies to become more accountable it is proposed that further training is made available aimed at reinforcing the interpretation and application of the definition of the threshold levels for intervention.

Recommendation 8 – Definition of assessment threshold levels
In order to address concerns relating to the understanding of thresholds among agencies and partners, the Director of Children Services (or LSCB) is requested to develop a training plan aimed at reinforcing the interpretation and application of the definition of the threshold levels for intervention. The training will equip responsible persons with the skills to identify levels of risk and take appropriate action.

In recent years, there has been an increasing drive for extended family members to become foster parents for the child utilising the legal process of Special Guardianship Orders (SGOs). Members heard mixed evidence regarding the benefits of the process as some practitioners argued that this does not always lead to the best outcomes, with particular concern being raised with the practice as social worker support is withdrawn once the Special Guardianship Order is in place.

In a local context, anecdotal evidence demonstrated that some of the SGOs put in place have been with extended family members who have had little ongoing relationship with the child. This suggests that more support for these families would be beneficial as, in some cases, these family members may have little intimate knowledge of the child.

The table below shows the increasing trend for SGO's more prevalent in the North West, among statistical neighbours and in England than in Wirral.

Table 5: Number of children who ceased to be looked after because of a Special Guardianship Order Historical Comparison (2012-2014)

	2012	2013	2014
Wirral	25.00	35.00	25.00
North West	430.00	470.00	570.00
Statistical Neighbours	22.14	18.75	26.67
England	2150.00	2770.00	3330.00

Source: Department of Education

However, research into Special Guardianship, "Investigating Special Guardianship: experiences, outcomes and challenges", published in November 2014 by the Department for Education, shows Special Guardianship to be an effective and positive option for some children who are unable to live with their birth parents to have a stable and secure family life.

The study demonstrated how local authorities are working proactively and successfully to use Special Guardianship Orders to help children for whom this is the most appropriate form of long term placement. It also found no evidence to suggest that the rise in Special Guardianship Orders has led to a diminishing use of adoption, nor that Local Authorities who encourage a high use of SGOs make less use of adoption.

However, the report does highlight the need for long term support for Special Guardians and the children in their care. It is, therefore, suggested that a process is put in place to ensure that appropriate support is made available to the family. Indeed, the British Association for Adoption and Fostering argues that the level of support provided to children in Special Guardianship Orders should be equivalent to the support that is available to adoptive families.

Recommendation 9 – Special Guardianship Orders
The Director of Children Services is requested to ensure that the processes in place to find Special Guardians are as robust as those for Foster Carers and Adopters so that all children placed under Special Guardianship Orders remain safe and are supported within that placement.

9.3 Partnership working

Strong leadership from all senior partners in local arrangements is essential to establishing an effective safeguarding system. In cases where there have been failures to safeguard effectively, reviews have often highlighted the absence of leadership and lack of partnership working as significant contributory factors. It is important that all parts of the local system are working closely together with good communications and a good appreciation of each other's roles. Effective multi-agency working is based on clear protocols and strong local relationships. Organisations including the Police, the NHS partners (health commissioners and providers), education services and probation services, as well as the voluntary and community sector all have their own accountabilities and statutory guidance to outline their roles and responsibilities.

Information sharing is an essential part of good local safeguarding arrangements. National research and analysis has indicated that failure to share information has been a significant feature of poor outcomes for children. The Members were told by a practitioner that:

> *"The biggest barrier is where information is not passed effectively between colleagues and partners agencies".*

At a local level, the LSCB has a crucial role in ensuring effective partnership working. It appears that this is a high priority for the local LSCB and that there is effective partnership engagement at this strategic level. The introduction of Wirral MASH has ensured that information is now shared more effectively although the members heard that the biggest single problem for the MASH is the delay in receiving information, with the longest delays typically being experienced with schools and the education sector. On numerous occasions during the review, the working relationship between a number of key agencies were complimented. Practitioners told Members:

> *"Local agencies are very good at identifying children at risk. The working relationship among agencies is very good".*

> *"In general, there are good relationships with all agencies".*

In practical terms, the Members were informed that if each agency operated independently, the intelligence gathered on a particular case may fall below the threshold and consequently would not be raised with social services. However, joint working can result in the identification of high risk when all of the evidence is joined together. The development of the Gateway also means that information regarding a family can be more easily shared to avoid more than one CAF (Common Assessment Framework) review taking place. Duplication of effort is, therefore, more likely to be avoided. However, a major hurdle remains with different partners employing a variety of computer systems, which are not integrated. On a practical level, this obviously makes information sharing and integration of practices more difficult to achieve.

There were some comments received during the review suggesting that not all partners were fully engaged during the assessment process and the preparation for child protection conferences. In particular, although third sector partners are well placed to provide information on families, due to both regular and informal contact, they are not always approached to do so during social care assessments.

Recommendation 10 – Involving all partners in social work assessments
The Director of Children Services is requested to ensure that all organisations involved with the child, including third sector organisations, are given the opportunity to provide information when social work assessments are being prepared.

Although, there appear to be good relationships across the partnership, including the health partners, some concerns were raised by social care practitioners that some agencies refer cases to social care too quickly without adequately investigating the circumstances themselves:

> *"There needs to be a change of focus, with other agencies dealing with families before referring the case to social care. Officers in other agencies are too scared and are risk averse".*

> *"There is a feeling that there is a lack of accountability for safeguarding issues displayed by some schools. People are terrified of making a mistake".*

In particular, there have been instances of "inappropriate" referrals from some GPs. It was also suggested that some GPs raise concerns regarding a child but are unwilling or unable to provide substantial evidence. A suggestion to improve the relationship with GPs is to provide more effective training to enable them to better understand the thresholds for action. In addition, while it is acknowledged that attendance at child protection conferences is time consuming and does impact on surgery times, a future option may be to encourage confidential written reports being sent to the Chair in advance of the conference.

Recommendation 11 – GPs and safeguarding
The Director of Children Services is requested to work in conjunction with Wirral Clinical Commissioning Group to develop a mechanism to encourage GPs to provide relevant information to safeguarding investigations and formal meetings. This mechanism could include a training programme for GPs to enable a better understanding of thresholds for intervention.

Members were told that some schools are very proactive regarding safeguarding issues and a lot of good work is going on in schools. The implementation of Operation Encompass is a positive development. This scheme involves key partners working together more effectively to alert school staff where a child has been present during an incident of domestic abuse. In turn, this enables the school to provide additional support to the child at a very early stage. However, Members were also informed that there is often a gap in intelligence during the summer holidays as it is particularly difficult to get anyone from schools to attend case meetings during that period.

It was also noted that there is a lack of consistency between schools and there is a discrepancy in the quality of response between schools. Those schools who deal with safeguarding issues on a regular basis tend to develop a confidence in doing so. However, those schools that have few referrals tend to be not so familiar with the processes. Members were informed by social care professionals that some schools appear to be reluctant to discuss safeguarding issues openly and honestly with parents as it can easily damage the relationship with parents. As outlined earlier, this can lead to schools referring cases to social care earlier than is perhaps necessary. The point was made that schools were equipped to deal with safeguarding issues but, at the same time, needed support from social care professionals to realise what they could do. It is, therefore, suggested that, in order to support schools in their safeguarding role, further work is done to help develop a stronger relationship between schools and social care. In addition, in order to avoid delays in information being reported by schools, it is suggested that the creation of a single specialist reference point for schools within the MASH model may be beneficial.

Recommendation 12 – Relationship between schools and MASH
In order to make it easier for schools to engage with safeguarding processes, the Director of Children Services is requested to consider the provision of a reference point for schools within the MASH.

Recommendation 13 – Relationship between social care and schools
The Director of Children Services is requested to consider ways in which stronger relationships can be developed between social workers and schools, in order to encourage all schools to become more integrated in the safeguarding process.

During the review, it was noted that there is a good relationship between the voluntary sector and social care and with the locality teams. It was also commented that those working in the third sector are experienced in assessment and the identification of risk. However, it was also reported that the options for training were limited for some partners in the voluntary sector, particularly some of the smaller organisations. While it is viable for some of the larger third sector organisations, such as Barnados and Homestart, to provide safeguarding training to staff and volunteers, that it is not necessarily the case for smaller bodies. As stated elsewhere, the quality of the training particularly that provided via the LSCB has been recognised by practitioners as being of high quality. It is, therefore, suggested that a process is developed to ensure that safeguarding training is made as accessible as possible, particularly to the smaller organisations in the third sector.

Recommendation 14 – Access to safeguarding training
The Director of Children Services is requested to develop a process to ensure that safeguarding training becomes more accessible especially to small organisations in the third sector.

The recent high profile events in Rotherham, Rochdale and Oxford, among other towns, have brought the issue of child sexual exploitation to national prominence. Professor Alexis Jay's report into the sexual exploitation of children in Rotherham has provided a wake-up call for the child protection sector as well as for the wider public. What has emerged is a series of high profile abuse cases, each highlighting systematic failures. The NSPCC report, 'How safe are our children? 2015' estimates that recorded sexual offences against children in England have risen by 39% in 2013/14 compared with the previous year. This rise could partially be accounted for by an increased willingness to report abuse following media focus on the issue. The NSPCC report continues:

> *"The child protection systems across the UK need to continue to adapt to new and emerging forms of abuse, including Child Sexual Exploitation (CSE). The systems need to help practitioners feel confident in identifying and protecting victims, as well as contributing to working towards preventing CSE in the first place. Social workers report concerns that "sexual abuse might go undetected when more evident indicators of neglect or physical abuse are*

presented" and that too frequently they "were operating without the support, time, knowledge and training they needed to ensure the identification of sexual abuse and the protection and well-being of extremely vulnerable children". In addition, there is evidence that suggests child protection processes and procedures tend to be designed for work with young children in a family context. Adolescents require a more sophisticated model of risk prevention and protection".

At a local level, child sexual exploitation has been highlighted as a priority within the annual report of the Wirral LSCB for the last two years (2013/14 and 2014/15). Local initiatives have included the launch of the www.listentomystory.co.uk media campaign and the performances of Chelsea's Choice theatre productions aimed at young people. The work planned for 2015/16 will continue to raise awareness of child sexual exploitation among children and young people, parents and carers, professionals and the wider community; demonstrating strategic leadership on this key issue.

Members have heard that, at a practical level, monthly meetings of the Multi Agency Child Sexual Exploitation (MACSE) group take place. The process is well embedded and is used to review the cases of those young people identified as being at risk of child sexual exploitation. The members were told that intelligence is developing and the quality of the publicity campaigns, led by the LSCB has been high. The child sexual exploitation team is now embedded within the MASH model, helping to deliver a holistic approach.

As identified in the NSPCC report, local evidence also suggested that specific training on the identification of those young people at risk of child sexual exploitation would be beneficial across the partnership, including the police.

Recommendation 15 – Child sexual exploitation training for front-line staff
The Director of Children Services is requested to continue to encourage the uptake of additional training opportunities for front-line staff, including the police, regarding child sexual exploitation.

7.4 Staffing issues

In the early stages of the review, members detected considerable frustration among staff who had been informed that a re-structuring along with allied pay increases for social workers was being planned but not yet implemented. Members were informed that pay was considerably less at Wirral than in neighbouring authorities for staff undertaking equivalent roles. The levels of pay have contributed to difficulties with the retention of staff. Members were informed that a significant turnover in social workers affects the relationship with children and families. The continuity of contact and the development of trust are very important. In fact, the loss of social workers and the resulting changes in workload has resulted in, for many children, the Independent Reviewing Officer (IRO) being the most consistent person in their life. Subsequent to those scrutiny review meetings, localised pay increases and a re-structuring of Specialist Services has been implemented. Although a recent report to the Council's Children Sub-Committee provided an update to members regarding the re-structuring of Specialist Services, Members propose that further review work takes place in due course to establish the effectiveness of the structural changes.

Recommendation 16 – Social Care re-organisation: Follow-up investigation by members
The Strategic Director of Transformation and Resources is requested to enable scrutiny members to arrange a follow-up session / workshop to evaluate the effectiveness of the re-organisation once the new Specialist services social care teams are embedded. The review, which will include front-line staff and possibly parents and families, will also monitor the success of the plans to achieve improved retention of staff.

The members were informed that current caseloads for an experienced social worker in Wirral are an average of 25, although there is recognition by management that this is an issue to be resolved. It is understood that recommendations from national reviews have placed the number for safe practice between 15 and 20. Members were told that there is significant pressure, particularly on those more experienced staff who are allocated complex cases. The pressure of workload has reportedly been a contributory factor to some staff leaving the authority. It was also reported that the volume of work and high caseloads has also contributed to a significant turnover of staff, particularly among the more experienced. As a result, the proportion of newly qualified staff has perhaps been higher than is desirable. Pressure of workload among experienced workers also means that there is less time to mentor newly qualified staff. It is anticipated that time pressures will also increase as the implementation of the Children and Families Act 2014 will ensure that care proceedings must be completed within 26 weeks rather than the previous limit of 52 weeks. Members, therefore, suggest that a process is put in place to reduce the caseload towards the national average.

Recommendation 17 – Social worker caseloads
The Director of Children Services is requested to develop a mechanism to monitor the caseloads of social workers with the aim of reducing the caseload to, at most, the national average.

Members were informed that it is a complex task to both chair case meetings and take the minutes. In addition, notes have to be hand-written and typed at a later date, resulting in potential delays in the issuing of minutes. Clerical support would ease the problem, although the provision of laptops or tablets would improve the ability of social workers to operate in a more flexible, agile and productive way. Although there will be a capital cost in providing new equipment, productivity gains would result in the longer-term.

Recommendation 18 – Social worker support
The Director of Children Services is requested to consider the options for increasing the availability of laptops for staff, such as social workers, who are regularly working off-site.

7.5 Governance arrangements

Local safeguarding arrangements are based on a national framework outlined in legislation and statutory guidance, 'Working Together to Safeguard Children'. Central to these arrangements are the statutory responsibilities of the local authority and the LSCB. Three senior safeguarding roles provide high-level leadership in this structure, namely, the Lead Member for Children's Services, the local authority Director of Children's Services and the chair of the LSCB. Each has their own accountabilities and together they share responsibility to work with multi-agency partners to promote the welfare of children and ensure they are properly safeguarded. Scrutiny Committees have a crucial role in ensuring that all officers and executive members are held to effective account for the fulfilment of these roles within the local structure.

A Local Safeguarding Children Board is established for each local authority area. Its role is to:

- Coordinate safeguarding in the local area.
- Ensure the effectiveness of safeguarding activities of all local partners.

The LSCB has a number of functions:

- To develop local policies and procedures for safeguarding.
- To establish thresholds for interventions when there are concerns about a child.
- To identify training, recruitment and supervision standards for all local partners.
- To raise awareness of safeguarding and best practice.
- To monitor and evaluate the effectiveness of local safeguarding including the individual and collective work of Board partners.
- To participate in the planning of services.
- To ensure that Serious Case Reviews are implemented where appropriate and lessons are shared.

Membership of the LSCB is made from a range of Board partners who are senior officers from local agencies including the Police, the Youth Offending Team and the Clinical Commissioning Group. Whilst LSCBs do not manage the delivery or commissioning of safeguarding services they will recommend priorities and areas for improvement. The Chair of the LSCB is an independent appointment charged with holding all agencies to account. Members heard complimentary comments regarding the quality of training, delivered across agencies, provided by the LSCB. Some witnesses described the LSCB training in Wirral to be of a higher standard than in a number of neighbouring Local Authorities.

At a national level, the Local Government Association recently commissioned a study to review the perceived effectiveness of LSCB's. Incorporating the views of Board chairs and partner agencies, the research concluded:

- the original purpose of the boards to coordinate local safeguarding work and ensure the effectiveness of local activity to keep children safe, has become confused by increasing expectations that are not matched by greater power or resources;
- significant progress has been made in building a strong joint approach to safeguarding across local areas, but in too many cases work was hampered by a dysfunctional Ofsted regime;
- inspectors too often judged success on a board's ability to correct failings of other organisations, even though Ofsted recently acknowledged in its own annual social care report that boards do not have the powers to do this;
- funding was not always shared equitably by all partners, and a disproportionate burden was often placed on councils as a result;
- the increasing independence of schools is making it harder to engage the education sector with local authority schools regularly represented but hardly any attendance from academies;
- whilst everyone recognises the importance of learning and sharing lessons of serious case reviews, they are often too bureaucratic, increasingly expensive and the resource required is disproportionate to their usefulness in improving practice; a new approach is needed.

During the review, Members visited a meeting of Wirral's Local Safeguarding Children Board, during which the robustness of the challenge was observed. However, Members have also noted the significant number of bodies within the Council who have an interest in safeguarding matters. These include:

- Local Safeguarding Children Board
- Children's Trust Board
- Safeguarding Reference Group
- Corporate Parenting Group
- Health & Wellbeing Board
- Families and Wellbeing Policy & Performance Committee

The possibility of duplication and overlap across these groups is, therefore, noted. As a result, it is proposed that a review of the specific roles relating to safeguarding issues is undertaken in order to avoid duplication but more importantly to ensure that the appropriate lines of accountability are in place.

Recommendation 19 – Governance arrangements
The Strategic Director for Families and Wellbeing is requested to undertake a review of the governance arrangements relating to safeguarding to ensure that remits of bodies, such as Children's Trust Board, Corporate Parenting Group, Health & Wellbeing Board, Local Safeguarding Children Board (LSCB), Safeguarding Reference Group and scrutiny, are clearly understood, the appropriate reporting lines are in place and that duplication of activity is avoided.

Both the reports produced in 2014 by Professor Jay and by the Communities and Local Government Select Committee highlight the failure of scrutiny and challenge within the system of governance at Rotherham. It was recommended by the Centre for Public Scrutiny that learning from the scrutiny process in Rotherham will be of benefit to scrutiny committees in all Local Authorities. Key lessons included:

- The need to check evidence and data presented to the scrutiny committee.
- The importance of councillors using their local knowledge to sense-check reports and approaches.
- A lack of measures to monitor the effectiveness of the scrutiny process.
- The importance of clarity between executive and scrutiny roles for members.
- The need to monitor the implementation of scrutiny recommendations.
- The need for clear and good quality minutes and records of scrutiny sessions.
- The need for effective challenge.
- The importance of using the scrutiny process to hold the executive to account.

The recent Report of Inspection of Rotherham MBC (February 2015), by Louise Casey presents further challenges for Local Government Scrutiny. Relating to scrutiny and standards, the report says:

> *"Inspectors saw regular reports to the Cabinet and Scrutiny committees, but not the effective challenge we would expect from elected Members. The notion of challenge has been misunderstood and misinterpreted as bullish questioning. Challenge means setting aspirational targets, knowing how far to stretch the organisation, asking searching questions, drilling down into information and data, ensuring targets are kept to and agreed actions implemented. It also means recognising organsational inertia and doing something about it; identifying when people are struggling, finding out why and getting alongside them, overcoming barriers and working out solutions.".*
>
> *"….it is not clear how effective it [scrutiny] has been in holding Cabinet Members and senior officers to account for their individual performance and decision-making. Inspectors could not find much evidence of how scrutiny had changed practice or policy making".*
>
> *"Inspectors concluded that overview and scrutiny had been deliberately weakened and under-valued. The structures and processes look superficially adequate, but the culture has been one where challenge and scrutiny were not welcome.*

In the past few years, the Annual safeguarding reports have been presented to members of the Families and Wellbeing Policy & Performance Committee (and prior committees). It is intended that the Chair of the LSCB, as well as appropriate officers, are invited to present such reports. However, in some Local Authorities, scrutiny committees have found it helpful to establish a protocol of understanding with the LSCB. This can help manage expectations and priorities and assist the LSCB in understanding the role of scrutiny and the types of evidence and information that the scrutiny committee will need. Whilst the Policy and Performance Committee will continue to receive annual reports from the LSCB, the development of a protocol will provide an opportunity to consider further ways to work together.

Recommendation 20 – The role for scrutiny in safeguarding
The Strategic Director of Transformation and Resources is requested to further examine the role of scrutiny in the safeguarding process by establishing a protocol of understanding with the Local Safeguarding Children Board (LSCB).

Appendix 1: Scope Document for the Safeguarding Children Scrutiny Review

Date: 12th June 2014 (Version 3)

Review Title: Safeguarding Children

Scrutiny Panel Chair: Cllr Moira McLaughlin	Contact details: moiramclaughlin@wirral.gov.uk
Panel members: Cllr Wendy Clements Cllr Cherry Povall Cllr Denise Roberts Cllr Jean Stapleton	wendyclements@wirral.gov.uk cherrypovall@wirral.gov.uk deniseroberts@wirral.gov.uk jeanstapleton@wirral.gov.uk
Scrutiny Officer: Alan Veitch	Contact details: 0151 691 8564 alanveitch@wirral.gov.uk
Departmental Link Officer: Simon Garner	Contact details: simongarner@wirral.gov.uk
Other Key Officer contacts:	

1**. Which of our strategic corporate objectives does this topic address?**
In particular, one of the priorities identified in the Corporate Plan (2014-16) for this year is:

"Ensure that safeguarding arrangements for vulnerable children and adults continue to strengthen, informed by national learning".

http://www.wirral.gov.uk/my-services/council-and-democracy/council-performance/corporate-plan

2. **What are the main issues?**

2.1 Agencies working with children need to understand and be effective in their contribution to protection plans. This is not a consistent picture.

2.2 The child's voice should be at the heart of every plan they may be subject to.

2.3 It is difficult for children and families to understand services and their relevance at each stage of involvement.

2.4 There is a key role to be played by the Local Safeguarding Children Board LSCB), having the ability to address these issues and it needs to be effective in doing so.

3. **The Committee's overall aim/objective in doing this work is:**

3.1 To inform the development of effective safeguarding practices both within the Council and across the Children's Partnership.

4. **The possible outputs/outcomes are:**
4.1 Partnership understanding that constructive working relationships will enable effective prevention and early intervention.
4.2 LSCB membership has people strategically placed to support any changes that are needed.
4.3 Frontline practitioners and managers are fully aware of the experience of families and what works best for them.
4.4 Barriers to working together are identified and addressed.
4.5 Elected members understand how safeguarding relates to their role in the community.

5. **What specific value can scrutiny add to this topic?**
Scrutiny will give members the opportunity to assure themselves that the Council and partners have adequate safeguarding mechanisms in place and that those processes work in practice. Scrutiny can also help the partnership to understand what the experience of families is and what may need to change to improve outcomes in safeguarding. Scrutiny can also explore best practice from elsewhere.

6. **Who will the Committee be trying to influence as part of its work?**
6.1 Appropriate Cabinet members and Directors, Wirral Borough Council.
6.2 Partners of the Council, for example, health and school partners
6.3 Strategic managers across the partnership
6.4 Local Safeguarding Children Board
6.5 Frontline Staff across the partnership

7. **Duration of enquiry?**
It is envisaged that the Review will last for approximately six months (that is before the end of 2014).

8. **What category does the review fall into?**

Policy Review	**Yes** ☐	Policy Development	☐
External Partnership	***Yes*** ☐	Performance Management	☐
Holding Executive to Account	☐		

9. **Extra resources needed? Would the investigation benefit from the co-operation of an expert witness?**
The review will be conducted by councillors with the support of existing officers. However, the panel are looking for advice from people with expertise on this topic.

10. **What information do we need?**	
10.1 **Secondary information (background information, existing reports, legislation, central government documents, etc).** Documents to include: Safeguarding Children Scrutiny Guide (A briefing paper produced by the Centre for Public Scrutiny and I&DeA) Wirral Safeguarding Children Board – Annual Report 2012-13 & Business Plan 2013-14 Wirral Safeguarding Children Board – Annual Report 2013-14 & Business Plan 2014-15 (Report due to be available in July 2014) Children services Performance Reports Ofsted Inspection of safeguarding and looked after children services (of Wirral Borough Council), March 2011 Working Together to Safeguard Children 2013 (A Department of Education guide to inter-agency working to safeguard and promote the welfare of children) Ofsted Social Care Annual report, 2012-13 'How Safe are our children? 2014' (Report published by NSPCC) 'In the child's time: professional responses to neglect' (Ofsted, March 2014)	10.2 **Primary/new evidence/information** Reflect on the views of families, agencies and staff: Review anonymised child protection plans Audit the journey of the child through early intervention to child protection Understand what cases are in the system now and how did they get there. Statistics regarding: • Numbers of children / caseloads • Sample profiles of workload • Current and historical numbers of child protection plans • Equivalent data from statistical neighbours Understand the Ofsted inspection framework. Identify Local Authorities who have failed inspections in the last year and what has been done to improve Review good practice examples of care protection plans Learn from other Local Authorities – Cheshire West & Chester Wirral Safeguarding Children Board minutes will be available

10.3 **Who can provide us with further relevant evidence? (Cabinet portfolio holder, officer, service user, general public, expert witness, etc).**	10.4 **What specific areas do we want them to cover when they give evidence?**
Contacts to include: Focus groups with practitioners (social workers) and frontline managers across targeted and specialist services (Contact is Emma Taylor / Deborah Gornick) Visit to see and understand the Multi Agency Safeguarding Hub – MASH. (Contact is Simon Garner) Interviews / focus groups with families who have received a safeguarding service. (Contact is Emma Taylor / Deborah Gornick) Meeting with the LSCB chair (Bernard Walker) and possibly other members LSCB Manager (David Robbins) Representatives of other agencies (for example, police, health visitors, schools, probation) Independent Reviewing Officers – IROs (Contact is Gill Clayton) Advocacy agencies / relevant third sector partners (Contact is Bev Morgan, Wirral Link Forum) Visit another Local Authority – Suggest Cheshire West & Chester Request attendance, as observers, at a meeting of the LSCB	The issues listed in Section 2 above The effectiveness and relevance of current processes Suggestions for any improvements

11. **What processes can we use to feed into the review? (site visits/observations, face-to-face questioning, telephone survey, written questionnaire, etc).**

Meetings with witnesses (as listed in 10.3 above)
Desktop analysis / research

12**. In what ways can we involve the public and at what stages? (consider whole range of consultative mechanisms, local committees and local ward mechanisms).**
12.1 Service users will be included in interviews / focus groups