# Children's Partnership Board Quality Assurance and Safeguarding – Children' Services January 2023

## Introduction

The previous report to the Partnership Board was in July 2022 following the introduction of a new Quality Assurance (QA) Framework in April 2022. Since this time, a variety of activity has continued to build momentum. The launch of the Quality Assurance Framework included:

- introducing a range of new and revised QA activity
- increasing our pool of reviewers
  offering training and support to build reviewer confidence and support consistency
- improving our reporting mechanisms via Power-Bi
- building the majority of our review tools into the child's electronic record
- being relentless in our determination to develop our QA system to inform and support practice improvements for our children and young people

We recognised the importance of ensuring we bring colleagues with us on the journey and that we develop the understanding that QA is 'everybody's business'. There is a noticeable shift in understanding of and attitude towards QA although challenges regarding capacity are ongoing.

Capacity within the Quality Assurance and Safeguarding Team was also an issue and investment in this team was identified as a priority. A permanent QA Officer started with us in October 2022 and the Team Manager capacity was increased from a part-time to a full-time role.

This report will summarise the activity undertaken since the last report to the Partnership Board.

# Summary of Activity, Findings and Actions since July 2022

## Collaborative Practice Review (CPR) Care Leaver's Service – SEP 22

15 reviews were allocated and 14 were successfully returned on time and moderated. (Fig.1)

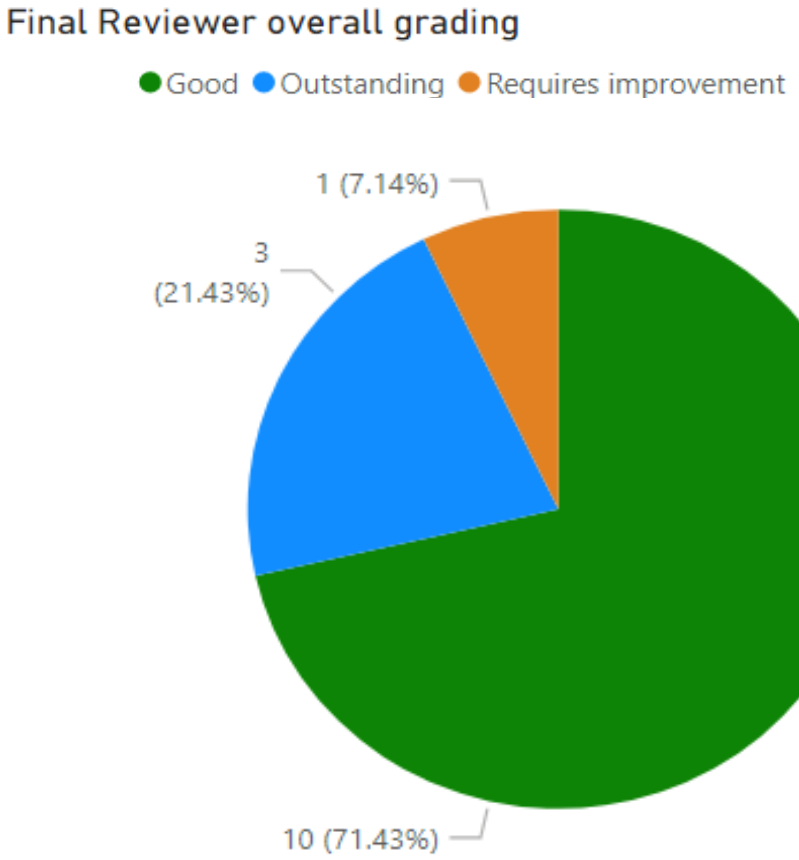


Fig.1 a chart of outcomes from Care Leavers CPR

**92.86% were graded Good or Outstanding**

Findings:

- Planning – Consistent and clearly written pathway plans, assessing the needs of the young people
- Relationships – Excellent evidence of caring, integrity and support shown by Personal Advisors to young people/care leavers
- Contact – Good evidence relating to different and regular types of contact - in person, phone, email
- Trust – Referred to across several reviews, good levels of trust between young people and staff
- Recording – Good evidence captured through quality of recordings on case notes, for example, "the voice of the young person was brought to life through good recording"

**7.14% were graded Requires Improvement**

- Some chronologies not up to date
- Limited support network not recorded appropriately
- Recordings not as clear as they could be

Recommendations made from this QA activity were as follows:

1. Signs of Safety practice approach to be more robustly embedded across the Corporate Parenting Service, including the family seeing aspect. Aspire to create and maintain stronger networks for children in care and ultimately care leavers that will support them well into adulthood.

2. A further opportunity to review the implementation of recommendations from the Team Spotlight completed in October 2022 and the above CPR to be organised in May 2023 via a repeat CPR, followed by the annual Team Spotlight, November 2023.

These recommendations were accepted by the QAPM meeting and therefore are being led by Head of Corporate Parenting.

## Themed Practice Review Child Protection Plans – OCT 22

**In October 2022** we undertook a themed practice review focused on Child Protection Plans. We received 16 returns, from 22 reviews allocated. (Fig.2)

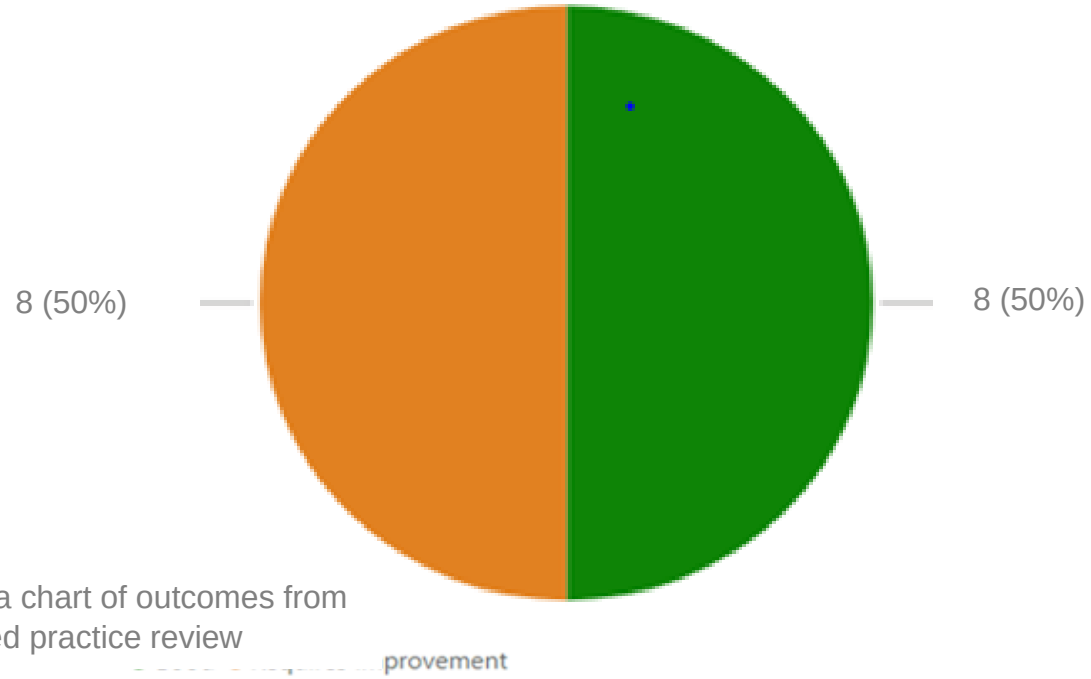


Fig.2 a chart of outcomes from themed practice review

**50% were graded Good**

- Family – Good examples of family engagement
- Plans – Good evidence of plans and clear rationale
- Children – Good examples of child engagement, understanding and appropriate language

**50% were graded Requires Improvement**

- Plans - Reported as sometimes not being clear or robust
- Extended family network – Referred to in case notes but not reflected in the plan
- Children – Children appear to not have been informed of plan, or not recorded as informed of the plan and more straightforward language needed to help the children understand

Recommendations made from this QA activity were as follows:

1. Develop family centric practice to ensure the impact of the associated processes enable participation as fully as possible, such as:

- Continue to develop our use of ‘language that cares’ and evidence in documentation
- Prepare families and children for upcoming meetings about them
- Family led safety planning to become integral to our practice with all families
- Increase children's understanding of their plans
- Exploring wider family/friends networks

2. Quality of minutes to be developed to reflect relevant information and rationale for decision-making.

These recommendations were accepted by the QAPM meeting and therefore are being led by relevant HOS for their service areas.

## Collaborative Practice Review Children in Need – NOV 22

We received 11 returns from 18 reviews allocated. This was a lower return rate compared to previous reviews. (Fig.3)

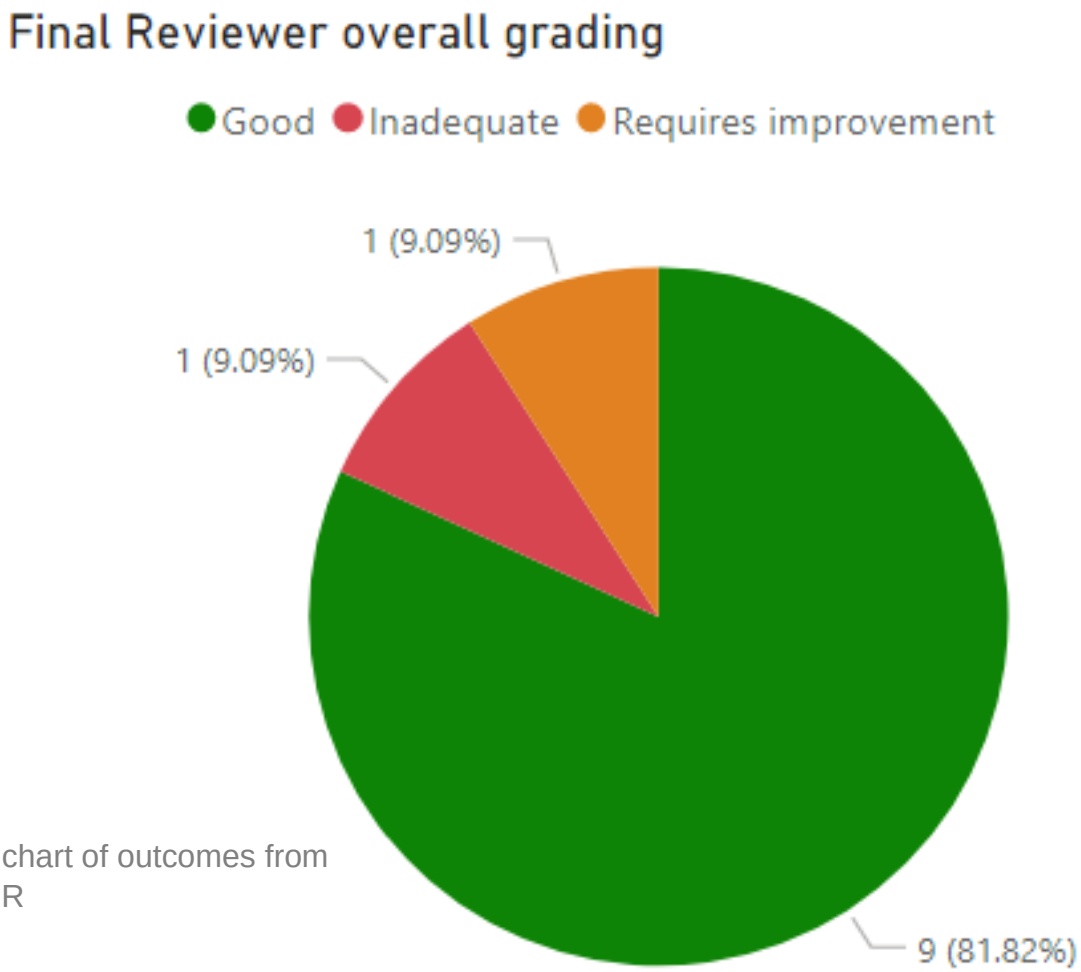


Fig.3 a chart of outcomes from CiN CPR

**82% were graded Good**

- Demographic – Good recording of information
- Language – Reviewers found records had been written using 'language that cares' and in a way that young people will understand
- Recording – Clear recording of information
- Recording - Danger statements and safety goals were clearly written

**18% were graded as Requires Improvement or Inadequate**

- Recordings – Not as clear as they could be
- Chronology – Some recording lacked depth, and some was not up to date
- Visits – Reviewers found some records not updated and therefore it was not evident whether children had been seen
- Visits – Reviewers found some records where visits surpassed 28 days for one child

Recommendations made from this QA activity were as follows:

1. All children and young people must be seen, and visits recorded within the timescales defined in our practice standards. This will strengthen our relationships and understanding of their lived experience and supports effective intervention and planning

2.Heads of Service and Team Managers to maintain rigorous oversight of visiting frequency via performance reports

3. Chronology's should not just be a list of negative events, they need to reflect the best and worst events for children and young people and the impact analysed and understood, therefore producing chronologies focussed on impact and not just events

4. Case Summaries to be updated every 3 months (or sooner if needs be) to ensure an up-to-date picture is available for quick reference and to support decision making and action

4. Scaling questions to be used alongside danger statements and safety goals to measure the impact of intervention and changes made and support a judgement as to the level of safety there is in place for the chid or young person

These recommendations are being presented to the QAPM meeting on the 16th January and therefore remain as recommendations currently.

## Collaborative Practice Review Children at Risk of Exploitation – DEC 22

23 reviews were allocated and 12 were successfully returned on time and moderation is now taking place. Follow up is underway on the 11 reviews outstanding to increase the return rate. An initial picture suggests out of the 12 returned, 6 were judged as Good and 6 were judged as Requires Improvement. Analysis of the findings from these CPRs will commence over the next few weeks.

## Team Spotlights

Annual Team Spotlights were introduced in July 2022 and, so far, we have undertaken Team Spotlights for the Fostering Service, the Leaving Care Service and the Independent Safeguarding and Reviewing Officer Service. The outcome judgment for each of the Team Spotlights was Requires Improvement and clear recommendations were made to support practice improvement and the journey to Good. The recommendations will translate to the annual service plans which have been written for January - December 2023 by the responsible Heads of Service.

By July 2023 every service area will have participated in their first Team Spotlight. Wherever possible, these will align with a Collaborative Practice Review which will take place 6 months later to seek assurance that recommendations made in the Team Spotlight are being put into place and having an impact.

## Closing the Loop Activity

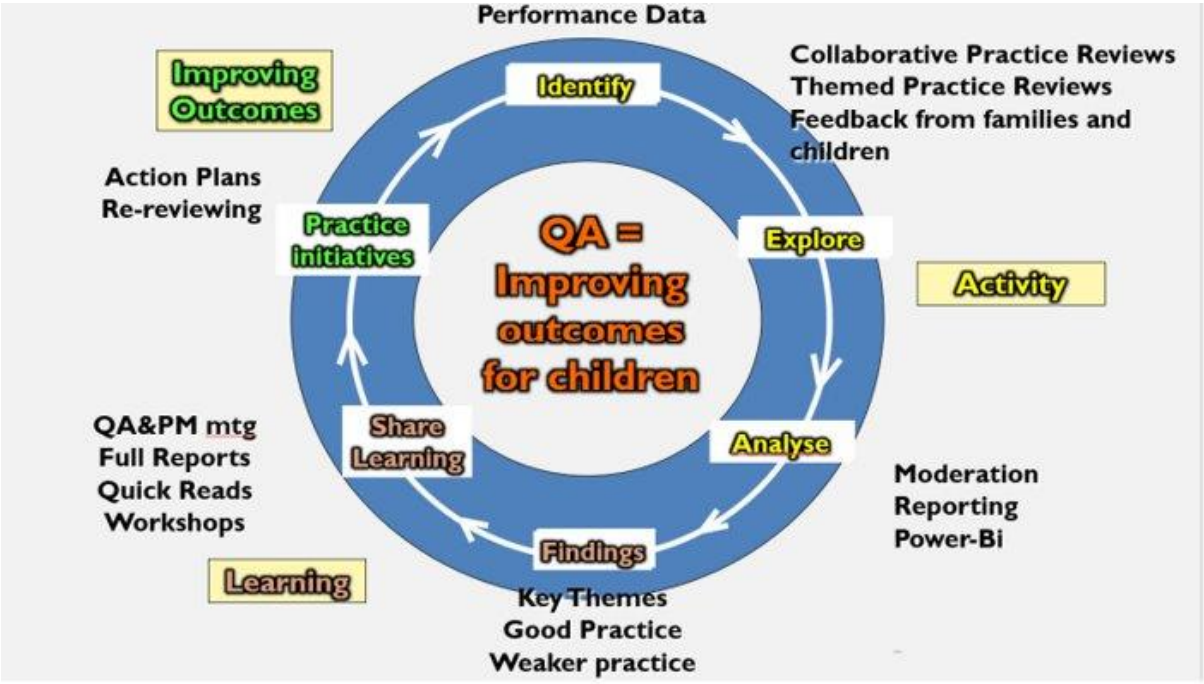


Fig.4 Closing the Loop flowchart

A fundamental aim of QA is to ensure we know ourselves well and can adjust our position and practice to emerging trends with agility, so children and their families receive the best possible service. Effective QA informs changes to practice and the infrastructure that supports practice such as policy, process, templates etc and then revisits and tests the impact of changes made following QA activity. It is important to allow sufficient time to develop and embed change. This is a key focus area in North Somerset.

### Decision Making at the Front Door

QA undertaken at the Front Door in August/September evidenced a lack of curiosity and triangulation of information in our decision making. An action to address this practice issue was developed and work has been ongoing. Performance data is now indicating the positive impact of this work which is, as reported to the December Partnership Board, a reduction in the number of No Further Action Outcomes (NFA) and a reduction in the number repeat Contacts where the outcome is NFA. The performance information also indicates a slight increase over time in numbers of referrals, children in need and children supported by Child Protection Plans whilst Children in Care numbers remain stable. This is considered an early indicator that we are aligning more closely to our statistical neighbours and national averages and that decision making is focused on children receiving the right support at the right time and by the right service.

## Strategy Discussions

**In January 2022**, a themed practice review exploring the quality of our Strategy Discussions was undertaken. These are multi-agency meetings convened when there is reasonable cause to believe a child is suffering or likely to suffer significant harm as defined in The Children Act 1989. An action plan was developed following this work. The actions included a multi-agency review of the practice guidance for strategy meetings and that strategy meetings for all new referrals should be re-located at the Front Door. These actions have been achieved. The findings of the review were also shared and discussed with Team Managers across the service to ensure the right is information is shared and the rationale for decision making and actions are clearly evidenced and recorded.

**In October 2022** we reviewed this practice and undertook a dip audit exploring those areas identified as Requires Improvement in January. We reviewed every strategy discussion for Children in Need that had taken place in the preceding fortnight. There were 16 children, who made up a combined total of 5 families. It is recognised this is a small cohort.

**Headline Findings**

- In January 2022, 44% of invited appropriate people/agencies attended strategy meetings. In October 2022 we can report 100% compliance in this area
- In January 2022 - 70% evidenced either good examples or good throughout in plans focused on the child. In October 2022 – 93.75% evidenced child focused plans
- In January 2022 - 56% of those invited to Strategy didn't attend, of those 66% provided no information into the process. In October 2022 – 100% of those invited to strategy attended. Furthermore, multiple professionals from partner agencies were present at some meetings
- In January 2022 – 56% of minutes were shared within 2 days. The longest being returned after 40 days. In October 2022 – 68.75% completed within timeframe. All minutes in the October Dip Audit were recorded in the correct subject heading on LCS, a further improvement from January's themed review

Overall, this exercise evidenced a positive improvement, notwithstanding some of these improvements needed to go further and be more consistent across the management group who chair strategy meetings and will remain a priority focus for the Heads of Service for Front Door, Family Support and Safeguarding and Corporate Parenting.

## Repeat Child Protection Plans

In July 2022, a Dip audit was undertaken on children on repeat Child Protection Plans (CPP). At the time of the audit, 14 children supported by CPPs had previously been on a CPP within a 2-year window.

The Dip audit identified that we were being overly optimistic, and that we lacked rigour in our exploration of evidence of safety. It was evident we were taking compliance as an indicator of safety. For example, a parent going to the doctors or meeting with the social worker was seen as offering safety. Safety is what successful strategies the family network is employing to keep the child safe from harm as part of a Safety Plan.

Currently, there are 9 children who are on a plan for the second time within the last 2 years - a reduction of 5 since July 2022. Every child returning to an Initial Child Protection Conference for a second or subsequent time is reviewed and learning shared.

In response to the Dip audit, development sessions have been held with the chairs of Child Protection Conferences to increase their confidence in our practice framework and their need to be more requiring of evidence from colleagues regarding the safety in place for children. Observations of Child Protection Conferences by the Team Manager and Head of Service have also begun. The chairs report an increase in confidence and more robust conversations in conference, particularly around stepping children down from CP plans and this rationale is now more obvious in written records.

## Permanence Planning

A review of children subject to Care and Placement Orders was undertaken in May 2022. The review provides an overview about the permanence planning and outcomes for this cohort of children in their adoption journey and identifies areas for development to improve permanence practice.

For the children in this cohort the review found that there was some well written and detailed information on their LCS records; there is evidence that social workers know their children well and see them regularly. The child in care (CIC) reviews always contain information written to the child to help them understand their story. Permanence options are considered however required actions to achieve permanence do not always follow in a timely way.

The review found that:

- Case supervision and the role of the Independent Reviewing Officers could provide more constructive challenge to support the progress of children's permanence plans
- Care planning does not always appear to consider an early permanence placement (EPP) when a care plan of adoption is being considered or

progressed. Some children are waiting a long time to move to a permanent family

- Adoption West (AW), alongside children's social workers, have a key role in identifying and providing the right adoption placement for children at the earliest opportunity

In response to the above, a Permanence Action Plan has been developed and includes the following key actions:

- Revision of Permanence Planning Practice Guidance to include the introduction of permanence planning meetings
- Delivery of Permanence Planning Workshops
- Refresh of Permanence Tracking
- Strengthening of the Independent Reviewing Office role in driving forward and maintaining oversight of permanence planning

A positive impact from this work has been an increase in the number of young children placed in early permanence placements in the last 12 months.

## Fundamentals

In September at the all-staff conference, our practice Fundamentals were launched. These arose from our QA activity and understanding of the areas of practice we need to strengthen, and they link to our Practice Framework. They are based on:

1. Relationships Matter
2. Seeing and Hearing
3. Understanding
4. Responding
5. Outcome Focussed Practice
6. Language that Cares

## Action Plans

In order to ensure recommendations from reviews and subsequent action plans are progressing and having the desired impact, we have reviewed the role of the Quality Assurance and Performance Monitoring process. Going forwards the recommendation is that this accountability will sit within the new Quality Assurance and Performance Board chaired by the DCS, therefore creating an opportunity for wider discussion and strengthened scrutiny and accountability.

## Voice of Children and their Families

The best arbiters of how good our practice is, are the people who receive our service. Hearing from our children, young people, and families is key. We know this is an area of improvement for us.

## Collaborative Practice Reviews

Seeking feedback from children and their families is an expectation built into our CPR process. Age, understanding, consent, and accessibility are some of the reasons which prevent this. Nevertheless, we are clear that, where possible and appropriate, every effort should be made.

In the themed review referred to above, the voice of the child was explored. Encouragingly, we saw some good practice in relation to this area. 7 reviews were returned with clear evidence throughout the child's records, 7 showed some evidence, and 2 had limited or no evidence which, according to the reviewer, was due to the young age of the child.

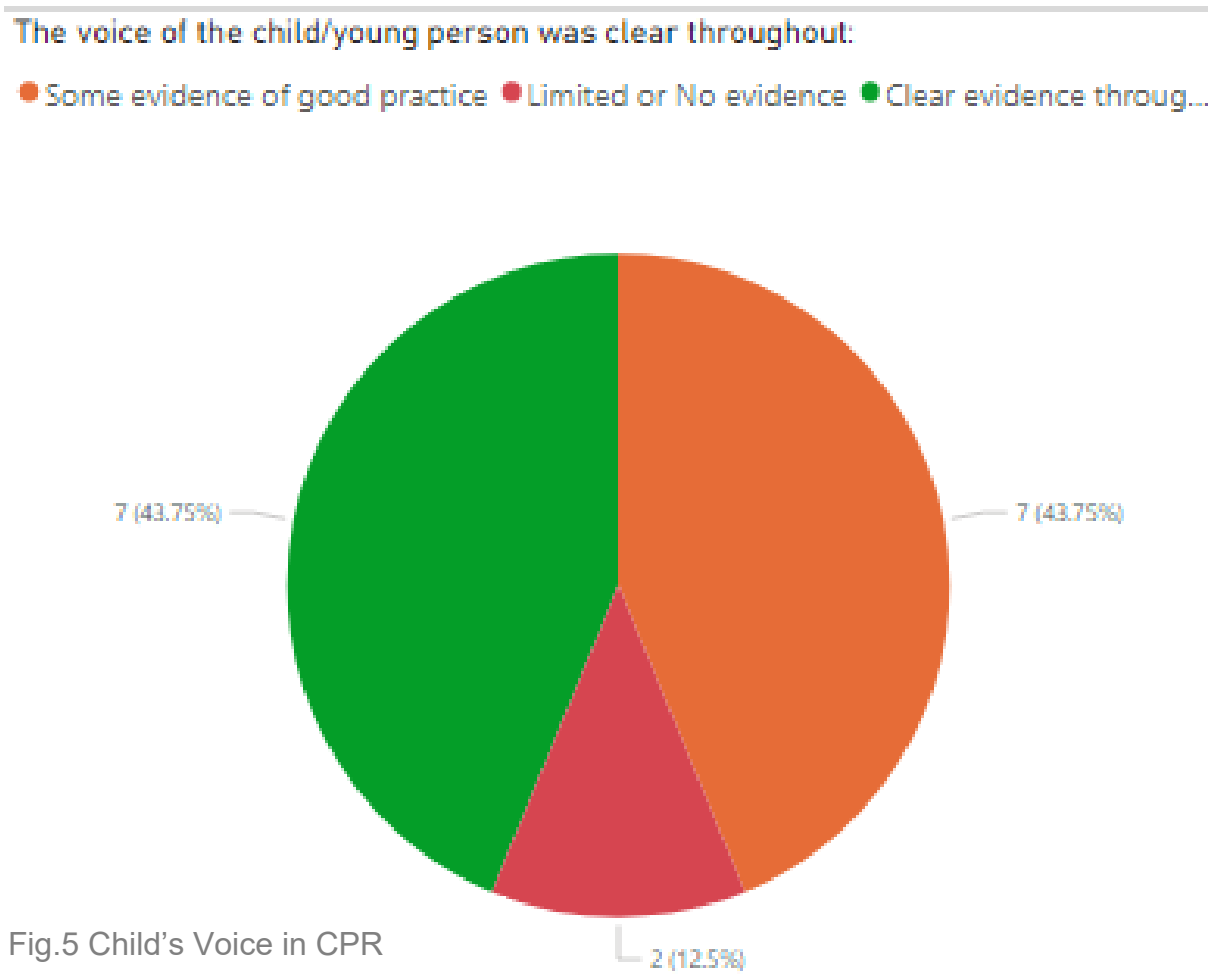


Fig.5 Child's Voice in CPR

**Good practice**

- The child's voice has been heard and evidenced within the reports
- Supporting case notes, evidencing the voice of the child

**Weaker practice**

- A safety house mentioned in case notes as being completed, but does not appear to have been uploaded
- The voice of the child was not very present in the report

In the Care Leavers CPR In September 2022, we were able to speak to 8 out of the 14 young people contacted. Here are some direct quotes:

- *"Staff go above and beyond in their support, they feel listened to and they really like that staff will always update them with any progress they have made on tasks"*
- *One young person described their PA as, "knowledgeable, understanding and amazing"*
- *"Staff have supported me to access education"*

In November's Child in Need CPR we were able to speak to 4 out of 13 children. Age of child and lack of parent consent were given as reasons for not being able to speak with children. The children we did speak to told us:

- *"They are nice, they help with things"*
- *"They helped nanny with Tesco vouchers"*
- *"I know I can talk to my social worker if I need help"*
- *"Too many workers involved"*

In the same CPR we spoke with 9 parents:

- *One parent felt the safety plan was negatively impacting his child's life*
- *Language could be used to help the child understand better*
- *Nothing could be done better*
- *Parents reported feeling supported*

## Corporate Parenting Board

The Corporate Parenting Board has seen the introduction of themed sessions. The focus of the sessions has been agreed with our Young Director in consultation with young people. The first session in July focused on education, training and employment and the session in September focused on accommodation for care leavers. Following these sessions action plans have been developed and feedback will be provided to our young people at future boards.

Our Young Director is currently undertaking various pieces of work linked to the voice of our children and young people and it is proposed that a separate report on this work is brought to the partnership board.

## Compliments and Complaints

All Compliments and Complaints now routinely get sent to the Complaints and Directorate Governance Manager, so they are responded to in a timely way and centrally stored. Bi-monthly reports are prepared by the manager for the Quality Assurance and Performance Review Board, collating the previous two months activity. The voice of children and their family needs to be more evident in these reports going forward, enabling us to learn from their experiences and ensure

learning is shared more widely amongst our colleagues. To do this, direct quotes from children, young people, and their families will be used wherever possible and the Team Managers and Complaints and Directorate Governance Manager will work closer together during complaints so this information can be ascertained and reported.

## Feedback Working Group

The Quality Assurance Officer is in the early stages of co-ordinating a group of colleagues exploring how we can more routinely hear from the parents and carers we work with. We know there is some very good practice in our Family Wellbeing Service (FWB) where the views of families have been very powerful and influential in service changes. To date we haven't replicated this success with the parents and carers supported by social care and whilst there are reasons why this is more difficult to achieve, our aim is to hear from the FWB service in the hope we can emulate some of their strategies and utilise some of their skills in this area so we can more routinely ascertain information from parents and carers supported by social care.

## Mind of My Own

To strengthen our work in this area in September 2022 we purchased Mind of My Own (MOMO) - a consultation tool for children and young people. We are currently rolling out the training programme and to date have trained ~70 practitioners and have 6 more sessions booked for 90 people. Alongside the consultation tool element, we also purchased the survey option, providing us with 3 annual surveys across Children's Services. For children supported by Child Protection and Child in Need plans our first survey is scheduled for February 2023, a cohort of child often difficult to hear from collectively.

## Next Steps

In addition to the QA activity identified in the QA timetable (Appendix 1), the following is planned:

- Repeat themed review into Supervision and Management Oversight in February 2023
- Recommendation Log following each round of core QA to be introduced in February 2023 to support Team Managers and Heads of Service to ensure all actions are undertaken and that this can be evidenced. This will be monitored via the Quality Assurance and Performance Review Meeting and Board
- Introduce a family survey – date to be confirmed following review of tool developed by Professor Eileen Munro
- Practice week – scheduled for week of 23rd January 2023
- Review of the bi-monthly Quality Assurance and Performance Monitoring Meeting to include a reporting requirement for Heads of Service

- Strengthen the clarity about the quality of practice in QA findings and recommendations to ensure clear understanding by the service
- Ensure a more robust and reactive response to learning and development needs identified via QA activity
- Introduce Team Manager audits in February 2023
- Complete further work to ensure confidence that reviewers are not over-optimistic and are consistent in their reviewing activity. This will include pairing reviewers for the February themed review
- Ensure that the impact of QA activity and subsequent learning and development can be evidenced in practice via feedback and further QA work.

Jo Ratcliffe

Head of Quality Assurance and Safeguarding

## Appendix 1 – Calendar of core QA activities

| January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Collaborative Practice Reviews | | Collaborative Practice Reviews | | Collaborative Practice Reviews | | Collaborative Practice Reviews | No core QA activity due to holiday period | Collaborative Practice Reviews | | Collaborative Practice Reviews | No core QA activity due to holiday period |
| Team Spotlight | Team Spotlight | Team Spotlight | Team Spotlight | Team Spotlight | Team Spotlight | Team Spotlight | | Team Spotlight | Team Spotlight | Team Spotlight | |
| Good Practice Conversation | | Good Practice Conversation | | Good Practice Conversation | | Good Practice Conversation | | Good Practice Conversation | | Good Practice Conversation | |
| CSLT – Action Planning | | | CSLT – Action Planning | | | CSLT – Action Planning | | | CSLT – Action Planning | | |
| QA&P Monitoring Meeting | | QA&P Monitoring Meeting | | QA&P Monitoring Meeting | | QA&P Monitoring Meeting | | QA&P Monitoring Meeting | | QA&P Monitoring Meeting | |
| | Thematic Reviews | | Thematic Reviews | | Thematic Reviews | | | Thematic Reviews | Practice Week | | |