Annex A: Quality Assurance and Inspection Readiness Thematic Overview Report

April 2020

1. Introduction

The Quality Assurance and Performance division have committed to deliver a comprehensive programme of thematic auditing to inform and assure ourselves we are delivering an improved standard of practice across the system.

Findings from the thematic auditing work and other activity across the Quality Assurance division are routinely reported to the Safeguarding Executive as part of their ongoing oversight & scrutiny of the improvement programme for Surrey's children's services. Feedback and follow-on actions resulting from the Executive meetings are discussed with the relevant Director where required.

This report brings together the key findings from the range of thematic audits that have been undertaken since January 2020 by the Quadrant based Inspection Leads. The focus of the thematic audits was agreed as part of the Inspection Readiness programme.

These thematic audits are one aspect of our quality assurance activity and should be seen alongside other measures in place to monitor the effectiveness and impact of practice.

Thematic audits (sometimes referred to as "deep dives") are a critical element in learning and improvement and allow for the better understanding of practice in a specific service area. They provide an opportunity to look at the quality of work undertaken with children and families. These consist of an agreed number of audits completed on a bespoke audit tool relevant to the area of scrutiny.

To date the following have been completed:

- Permanency for Children
- Private Fostering
- Pathway Planning for Children Looked After and Children Leaving Care
- Children Missing from Home, Placement or Education
- Children Placed at Home with Parents Subject to a Care Order

The emerging themes from these in-depth reviews are included below.

2. Permanency Process Review

2.1. A total of 61 children's cases were audited (North West 15; North East 15; South West 16; and South East 15). The inspection leads have spoken with managers, practitioners, IROs and business support as part of the audit process. The interim report highlighted that the 4 Quadrants were not influenced in their working by the permanency planning and tracking guidance.

2.2. Some of the key findings from the audit are detailed below and include quotes from managers and practitioners on the impact of the work *(for more detailed findings in respect of each Quadrant please see Midway Thematic Report January 2020).*

- Permanency planning meetings are not being managed effectively to ensure drift and delay is limited.
- There is a lack of evidence that permanency policy is followed and driving our planning in respect of children and young people.
- A permanence plan is not always in place by the second looked after review meeting.
- The spreadsheets being used for tracking all children is different in each Quadrant and does not provide a clear overview of what the outcomes/plan/tracking is for children considered at the PPM.
- Tracker PPMs are not routinely booked and are not held within 1 month (for under 5s) or 3 months (for over 5s). This impacted on the progress of parallel care planning being considered, discussed or progress monitored.
- Court timescales are adhered to and the court process appears to drive the permanence planning.
- The voice of the child and parents were not always evident within PPMs.
- Limited evidence of FGC's being used to identify family and friends to be assessed early on in our involvement.
- Limited evidence of supervision and management oversight and only when children are in proceedings the Court timetable is prioritised.
- The Social Worker and Team Manager do not always attend the PPMs.

2.3. What is evident is that the 4 Quadrants are not influenced in their working by the permanency planning and tracking guidance. There is evidence of a lack of understanding amongst some staff around the Permanence Policy and what is expected. This can be improved upon by raising awareness of the requirements and being consistent in the use of key documents across the Quadrants. Within each Quadrant the Inspection Leads have identified practice issues to be addressed and they will continue to work to support the implementation of solutions alongside staff. The statements below come from a range of practitioners interviewed.

- *"The PPM meetings are more robust in terms of the key expectations, with a refined focus on tackling issues of drift and poor planning. The chair is able to hold other Service Managers to account for poor practice issues and will escalate to Assistant Directors if needed."*
- *"In terms of the social workers' understanding of Permanency Planning, since the initial discussions that we held with the team after the recent Mock Inspections there has been a significant improvement. Workers are aware of triple planning and can refer to flow charts and guidance which is displayed in their work area."*
- *"There is an openness to consider alternative views, acceptance of needing to read policies in more detail and following those in practice. Staff have reported back how useful the related policies and procedures are."*

2.4. The actions identified from the interim thematic audit report (January 2020) have been progressed and include:

- The permanency tracking tool has been revised and it is now possible to automatically book children's cases for review, and to easily collate and report on information for this cohort of children and young people.
- A revised referral form & minutes form has been devised for PPM.

- Draft terms of reference have been devised outlining the purpose and focus of PPMs. This includes a recommendation for the collation of information on a quarterly basis to be provided to ADs & PLT on the number of children reviewed, the outcomes, themes and any practice issues identified.
- Permanency Workshops were arranged to take place in all quadrants. 3 of the 5 workshops were delivered last month however the final 2 have been postponed due to the impact of Covid-19. An interim solution is to disseminate key information to practitioners, managers and Chairs/IROs.
- All of the above has been shared with ADs for comment (6th April 20) and discussed at PLT prior to implementation across the Quadrants.

Next Steps: Quality Assurance will undertake a further review in approximately 6 months.

3. Private Fostering

3.1. 21 children's (12 female and 9 male) private fostering arrangements have been audited. This was based on reviewing children's and adult carer's case records, as well as speaking directly with social workers and meeting with the Team Manager responsible for Private Fostering.

3.2. Some of the key findings included:

- Initial visits were primarily completed within the required timescale once a notification had been received but subsequent visits were not routinely carried out in timescale.
- Children are generally seen regularly and alone.
- Contact arrangements between the child and their family were clearly identified.
- Where there were any specific health issues and needs for the child these were addressed with the carers and identified how they would manage and monitor their needs.
- Educational provision was in place for all of the children audited.
- Management oversight and supervision was variable in both frequency and quality.
- There were a small number of cases where safeguarding concerns were not effectively risk assessed.
- Assessments varied in quality, there was a lack of evidence of analysis, curiosity and challenge. They did not always fully explore the carer's parenting capacity to meet the child's needs, or seek the views of child's parents and involved extended family members.
- Health and safety checks were referenced as being completed but this was not always supported by a copy of the document being available on the case records.
- Lack of consistency around undertaking DBS checks on all adults/those over 16 in the household and also tracking and referencing the outcome of the DBS checks on the case records.
- There was limited evidence of the LA's engagement with parents, or encouraging a written agreement to be made between the parent and private foster carer to set out the expectations.
- Practice standards need to be consistently applied, for example suitability of accommodation, whether the child or young person has their own room/bed.
- Where operational teams are involved with a child placed in private fostering arrangement, practice was not always joined up in terms of communication and information sharing and how this informs the plans for the child.

- The need to raise awareness of private fostering both internally and in the wider community.

3.3. The following recommendations were made in response to the audit findings:

- A review of the existing Private Fostering policy will be undertaken - to include a review of the awareness raising letter and a guidance document for initial visits and assessments.
- To review and agree a clear set of practice standards to assist practitioners in their role of assessing carers and determining the carers' suitability and that of the accommodation.
- For the Family & Friends Team to agree a protocol of joint working where children are allocated in the Family Safeguarding teams.
- To agree an escalation process to alert of any safeguarding concerns.
- To devise an 'awareness raising programme' that targets those organisations that regularly refer international students, and internally with social work teams.
- To ensure there is oversight from the Children's Workforce Academy in providing any relevant training for practitioners within the Family and Friends Team.
- To identify ways to meet any training/support needs of private foster carers.

Next Steps: The Service Manager has implemented an action plan in taking into account the recommendations:

1.	**Review of policy and procedures across fostering and assessment teams.**	**Clear structure and procedure across the county and to enable accountability. It is clear who should escalate concerns and how these are escalated.**	**SM / Team Managers/ SSW**	**09/09/2020**
2.	**Agree practice standards and implement a Private Fostering Panel to review assessments.**	**Implementation of PF panel to ensure consistent quality and expectations of assessment. Panel member will include safeguarding SM.**	**SM / Team Managers/ SSW**	**09/09/2020**
3.	**100 % of IV and assessments are to be compliant and met within time scales. To be added to the assessment tracker with Business support.**	**Assessment to be added to monthly tracker, so that SM is able to track by compliancy and Business Support are able to track and ensure all checks are followed through.**	**Business Support Manager/TM and SM.**	**09/09/2020**
4.	**PF awareness programme to be part of the wider strategy for Fostering.**	**A rotating programme of raising awareness in the community and locally to be**		**01/04/2020**

		included in the wider marketing Strategy.		

4. Pathway Planning for Looked After Children and Children Leaving Care

4.1. A thematic audit focusing on pathway plans has been undertaken to review how practitioners prepare young people once they turn sixteen to help them make the transition from care to independent life and into adulthood.

4.2. A cohort sample was undertaken from each Quadrant (including Looked After, Care Leaver and CWD Teams). A bespoke audit tool was devised and the audit process included consulting with social workers, personal advisers, managers and where appropriate young people. A total of 91 pathway plans were audited as part of the thematic process.

4.3. The key findings from the audit are as follows:

- Majority of the plans are undertaken with young people but there was a lack of evidence that the completed plans are routinely shared with young people.
- The quality of pathway plans was variable, the focus was not always on actually preparing them for independence in sufficient detail.
- A range of young people of differing needs, was captured in the cohort sample, there was evidence of some young people progressing well and coping with living independently be they in further education, training or working; care leaver parents (both as mothers and fathers) and those struggling with managing the transition.
- A difference was observed in the quality of plans completed for those under 18 and those over 18 completed by personal advisers (PAs). In general, the PAs were more confident in talking about the young person's needs and the pathway plan process than social workers from the looked after teams.
- Plans would benefit from clearly setting out the young person's needs and capabilities so that it additionally informs for example, any recommended move into semi-independent or supported lodgings.
- There was limited evidence that young people were being supported to take ownership of their plans and level of understanding around the purpose of the plan. There was limited understanding of the young person's history and how this impacts on them as young adults.
- Plans should be more personalised and limit the use of generic phrases and links. Plans did not always evidence an analysis or partnership working to show that work completed will be meaningful and support young people through the transition to adulthood. Plans should evidence the incremental steps taken to supporting the young person to acquire the range of life skills will need.
- The management oversight in respect of quality assuring plans and authorising them was variable.
- For IROs to have a more prominent role in quality assuring that young people are involved in completion of their plans and the purposefulness of those plans.
- For young people with limited leave to remain the pathway plans did not consistently incorporate planning on the basis if they remain in the UK and equally if they are refused leave to remain.
- Preparation for independence needs to start earlier, as there were examples where care leavers did not have the requisite skills to manage and sustain living independently even as they approached the ages of 21 and 25.

- For plans to include contingency planning, for example, young people know what to do and where to go in an emergency, or if do not pursue further education but decide to take a gap year in the event they do not obtain their required results.
- Clarity is not always provided across the care leaver teams about how and when to end our involvement with care leavers post 21, leading to inconsistencies in practice.

4.4. **Recommendations:**

i) For the report to be shared with the Service Manager Children's Workforce Academy to consider the audit findings to feed into the wider training offer to social workers and personal advisers in respect of preparation for independence.

ii) Inspection leads to dip sample the quality and purposefulness of plans in 4 months' time.

5. Children Missing from Home, Placement or Education:

5.1. This thematic audit focussed on children who had reports as being missing from home and placement with an additional cohort of children who are 'missing' from Education due to no school placement. Ten percent of children who had a missing episode during this time were randomly selected for the audit.

5.2. The key findings from this audit included:

- When the missing episode was 'started correctly', the process in terms of completing the RHI was consistently completed, including the management oversight. There were gaps observed in the consistency of recording key information within the missing episode which creates difficulty in terms of understanding whether practice standards were followed.
- Quality of safety plans was variable and not consistently recorded within the missing episode. Supervision did not consistently develop the safety plans further, address or review action points. When safety plans were of good quality the family and professional network were able to get a clear understanding of how to safeguard the child.
- The threshold for holding a strategy meeting where there had been 3 missing episodes within a 90 day period was not consistently understood or followed.
- For children who are looked after an intervention meeting commonly takes place when there are longer/significant absences and for children who repeatedly go missing.
- This audit found that the response to and service provided to children who are missing from home and placement, and in some instances no education placement, continues to be inconsistent and compliance with practice standards it not always met.
- RMM's are mostly taking place for children when threshold is met, and the recording of these meetings is easy to locate within case notes.
- Professional curiosity and triangulation of the reasons why children are missing will assist the analysis, however there is more work needed to consistently achieve this. When more professionals are involved, such as the IRO this area of practice was stronger.
- Recording and monitoring of children missing from education was assessed to require a lot of improvement. The auditors formed the view from reading children's records that the right level of priority is not placed on education, creating drift and limited understanding of the role that social workers have had in improving educational outcomes for these children.

5.3. **Areas for Practice Improvement:**

- Safety plan to be clearly outlined in the RHI, specifically within management oversight.
- Safety plan to be reviewed on a regular basis and analysed within supervision and updated within the child's case summary.
- Ensuring relevant information following missing episodes are correctly recorded in Missing Episode case notes.
- It is important to record who is the first person to see the child in the RHI, whether it is the Police officer, worker at the residential unit etc.
- If the child does not engage with the RHI, clear evidence about the reasons behind this and analysis of the impact on the child is essential. Policy states that all attempts should be made to engage the child including completing the RHI at a statutory visit if necessary.
- If RHI is allocated to a worker who is not allocated to the child there should be analysis within management oversight as to why that decision has been made and any discussions had with the allocated social worker to understand the needs of the child.
- Keep safe work to be undertaken with children. This was provided by an independent fostering agency and would appear a valuable piece of direct work when engaging children and managing risk.
- There should be a clear education pathway to shore up the gaps to ensure that children's education is not disrupted to prolonged periods of time.
- There should be clear plans in place, and reviewed at regular intervals, to discuss and agree a way to address and manage education issues.
- There needs to be standardised recording of intervention meetings to ensure that it is possible to track the timeliness of these meetings in line with practice standards.

6. Children Placed at Home with Parents Subject to a Care Order

6.1. This audit is based on a cohort of 10 children and is in the process of being concluded. Alongside the case audit, there was consultation with social workers, IROs and managers.

6.2. The key themes include:

- Social workers listened to the views of the child/young person about returning home.
- Supervision frequency and quality was variable and does not consistently guide and reflect on the work being progressed.
- Where the return home was unplanned the Local Authority's initial response was timely.
- Where overnight contact was in place prior to the child's return home this provided the family to begin making adjustments and address the impact on the child and the rest of the family in the home.
- Where children have returned to parents in an unplanned way with a subsequent assessment this tends to ratify placement rather that assess its suitability in terms of meeting the child needs.
- There was an absence of written agreements with parents, addressing how they intend to safeguard their child once home.

- There was an absence of contingency planning in the event of placement breakdown, practice in this area was noted to be more re-active to situations and with less of a focus on forward planning.
- Agency checks are not consistently evidenced as being completed in respect of the parent/carer and adults within the household, or for those in regular contact with the child.
- Where there was information on mental health or substance misuse this tended to be self-reported by the parent/carer with a lack of verification to follow up the information.
- The need to evidence the detail of the direct work and preparation undertaken with the child/ young people for their return home.

6.3. **Recommendations:**

i) Supervision and management oversight to be delivered in line with procedural guidance to limit drift and delay, review the plan and guide work, quality assessments that include agency checks, risk assessment, focus on parenting capacity and the ability to safeguard and promote the child's welfare, IRO consultation; as well as ensuring that due process is followed and authorisation obtained by Assistant Director**.**
https://www.proceduresonline.com/surrey/cs/using_this_manual.html

7. Future Thematic Audits

The following thematic audits are underway:

- Placement Stability – led by the Inspection Leads
- YOS & Early Help – led by the Practice Audit and Standards Team
- Supervision – led by the Principal Social Worker
- FGC & Family Network Meeting – led by the Practice Audit and Standards Team

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