Quality Assurance and Inspection Readiness Thematic Overview Report September 2020

1. Introduction

The Quality Assurance Service remains committed to working collaboratively to drive practice improvements through evidence-based learning and support. A key element of the thematic programme includes consulting with managers and practitioners, which also provides the opportunity and space to reflect on the work through their engagement. This informs our understanding of practice from their perspective and approach to the ways in which practice can be improved and become more consistent.

Throughout August 2020 there was the opportunity to focus on embedding learning from the themed audits completed as well as the Inspection Leads' work alongside their operational colleagues to provide support on practice areas specific to each Quadrant, as identified by Service Managers and Assistant Directors. The Inspection Leads along with the Audit and Practice Leads attend the Quadrant practice challenge meetings which is also the forum through which to share learning and engage in quality assurance discussions.

2. Placement Stability

As part of our inspection readiness programme this thematic audit provides the opportunity to review the effectiveness of practice in relation to children and young people who have experienced 3 placement moves or more in the last twelve months. This review will allow our services to better understand the quality of practice within these areas and progress any required improvements.

Placement instability affects children's ability to develop both secure attachments and may exacerbate any behavioural and emotional difficulties being exhibited by the child. For children who experience multiple placements, it is known this has a detrimental impact on their psychological, social and academic outcomes, alongside their ability to form meaningful attachments.

In April 2020 there were 75 children and young people who had experienced 3 or more placement moves in the last 12 months. At this time there were 972 children looked after.

Age Range	0-5	6-12	13-17
No. of children	7 (9%)	12 (16%)	57 (75%)

There are a number of factors that contribute to placement breakdown and instability. This audit highlighted placement moves were both planned and unplanned. In acknowledging placement changes can be necessary and inevitable the aim is to try to minimise the number of placements children experience due to the impact of the move.

Ways in which we can mitigate this is to use the processes we have in place through fully utilising and complying with,

- placement planning meetings
- placement stability and disruption meetings
- timely intervention when concerns arise robust care planning including contingency plans to limit drift and secure permanence
- placement choice (including skills set of carers and providers)

- multi-disciplinary support

For Surrey to increase its placement sufficiency, to gain more suitable in-house provision (including residential) and continue to develop the Mockingbird project to assist supporting placement stability.

The challenge will be for practitioners and managers to consider how best to respond to the audit findings, focusing on progressing plans to have in place a range of options with a view to being able to identify the right placement for a child or young person, thereby creating the conditions that will provide both stability and a sense of permanence for the child. As we know good relationships with carers/providers contribute to placement stability helping to build important relationships and secure attachments, strong sense of belonging and identity.

Involving children in decision making can improve the quality of decisions and leads to more stable placements. The views and wishes of the child (where appropriate) should be duly considered and informing this process should also be an up to date assessment and care plan.

Considerable work is already ongoing to address some of the key issues identified in this thematic audit; however, the challenge will be for practitioners and managers to improve the basic practice issues in their operational responsibilities and role in contributing to quality placements for children.

A meeting has been held with Jo Rabbitte (Assistant Director for Children's Resources) to discuss the key findings and current sufficiency strategy, where there is a project management and whole systems approach to placement stability and permanency.

3. Family Group Conference and Family Network Meetings

The Audit and Practice Standards Team worked together with the Family Group Conference Service to review children referred to the Family Group Conference Team (FGC). The sample consisted of 28 children who had been referred to the service between April to December 2019 from across all four quadrants.

The audit also sought to understand if an FGC did not take place whether a Family Network Meeting (FNM) took place, and whether supervision is present to drive and review the FGC/FNM process and review the family plan.

The positive practice within the review highlighted that there was only a very small percentage of families who experienced a delay in the FGC service accepting and/or processing a referral. The FGC meeting took place on average 3-5 weeks after the referral (which is within the 6-week practice standards guidance), and there is evidence of good outcomes achieved for families when the service was implemented as it is designed.

The review also highlighted that FGCs are not considered early enough in the child's journey within our service, there is a delay in referrals being made once it is discussed and agreed within the social work teams. There is limited evidence to support that FGC's and FNM's are being discussed with families at the assessment stage of intervention. If an FGC has taken place and a plan has been agreed, this plan is not included in the child CIN, CP or CLA plan. It is not routine practice to refer for an FGC before an ICPC, or if entering care proceedings, the court will request for an FGC to be convened. There is evidence of IRO's and CPC's promoting FGC's / FNM's, but this is not routine practice.

When an FGC does not take place, there is minimal evidence to support that an FNM is then discussed or arranged with the family by the social worker. The overall findings of this audit are that Family Group Conferences / Family Network Meetings are not being considered early enough within our intervention or life of the case.

The outcome of the report has been shared with the Practice Leadership Team and all frontline teams. The Audit and Practice Standards Leads are have discussed the outcome of the report and practice improvements required in area manager's meetings.

Actions being implemented:

I. The FGC Team will be continuing to deliver FNM training to frontline teams on a virtual basis as this has proven to result in good attendance. This is available to all frontline services.
II. For Independent Chairs to have a more prominent role in quality assuring that FGC's and FNM's are considered throughout the CLA and CP process and that agreed family plans are included in CLA and CP plans.
III. For all permanency planning meetings to evidence consideration of a referral to the FGC team and if this is not appropriate to evidence the rationale as to why no referral for an FGC was made.
IV. Further review in 6 months.

4. Review of Youth Offending Service

In July 2020, The Audit and Practice Standards Team completed a review of the quality of service provided to children who are/have been made subject to Court and Out of Court Disposals (OoCD), including children subject to Youth Restorative Intervention programmes (YRI). The sample consisted of 27 children across all four quadrants and the tool was based on the Case Assessment Rules and Guidance (CARaG). The review was a fully collaborative process with the Youth Justice and Targeted Youth Service from the development of the tool, completion of audits, moderation, and follow up on every child audited.

The full thematic report outlined several key areas of practice within the Youth Offending Service and Targeted Youth Service but overall it found a trajectory of improvements made since the HMIP Inspection 2019, but the rate of improvements is variable.

The audit ratings assessed 18% of children receive a Good service, 39% of children receive a service that Requires Improvement, and 43% of children receive an Inadequate service.

One key area where practice needs to improve relates to the quality and timeliness of the assessments being completed for cases where the child is subject to a YRI or OoCD.

A second area of improvement is in relation to assessments in both cohorts which failed to comment sufficiently on the risk of harm to others as well as to the child.

Lastly, in a small number of cases the auditor was concerned regarding the workers understanding and analysis of factors for and against desistance which ultimately can impact planning and management grip. The recommendations and on-going work are to fully understand the practice inconsistencies across quadrants in order to create rapid improvement, consolidate improvements made so far, focus training on key practice areas identified, and re-assert the expectations of YOS case management guidance in order to reinforce robust management oversight.

Findings from this thematic audit were discussed with the YOS Senior Staff Team during moderation sessions and agreement was reached in respect of where improvements needed to be made. YOS Management Team have spent time revising their Training and Development Plan as a result of this review.

Actions being implemented:

1. Team Managers to review all the cases that remain open where a grade of inadequate was given and take urgent remedial action taken to address weaknesses identified.
2. The YOS learning and development plans should prioritise the delivery of learning opportunities to fill gaps in skills and knowledge.
3. The learning from this thematic review to be tabled at into the new Practice Development Working group, who will be responsible for addressing practice improvements required.
4. Establish joint YOS/ SATS action learning sets to establish better and more routine collaborative working between allocated social workers and TYS staff holding YOS work.

5. Independent Chair engagement with children, young people, parents and carers.

The Service Manager for Quality Assurance requested for a piece of work to be undertaken evaluating the quality and impact of the Independent Chairs engagement with children, young people, parents/carers. This is in the process of being concluded but the main areas of focus include;

- the level of preparation and engagement pre-conference/review meeting
- how children/families' culture and identity are addressed and used to inform the engagement process
- evidence of midway reviews and care progress updates and whether they are timely and progresses plans for the child
- if the child/parent/carers do not attend the conference/review meeting is feedback provided by the Chair
- if concerns are raised by the child/parent/carer how are they taken forward and addressed
- whether the engagement is effective in terms of securing good outcomes for children

The cohort sample comprised of 58 children, where the aim was for each Chair to have two children randomly selected.

Emerging themes:

- There is evidence of Chair's engagement outside of the conference and review process but this is not consistent practice undertaken by all Chairs.
- The Chairs footprint in terms of robustly driving plans is not always fully captured.
- Concerns raised by a child or parent with the Chair resulted in action being taken and the matter addressed.
- Examples of midway and care progress dates being set as part of the conference/review meeting.
- Good practice in terms of Chairs ensuring the young person fully understood their role and looked after review process.
- Chair convened an additional looked after review before the young person turned 18 due to concerns around the lack of clarity re post 18 arrangements.
- Escalation of concerns raised by Chairs led to and Service Co-ordinators chairing meetings with operational team colleagues. This is seen alongside evidence of where escalations could

be raised in more timely manner or where an escalation is closed too soon before the concerns have been fully addressed.

- There was one example of looked after minutes being written as if directly addressing the child.
- There was limited evidence that sufficient time is being given to speak with parents and children before conferences/reviews. But there was a good example where the Chair made arrangements to meet individually with parents to seek their views and provide updates.
- Efforts made to communicate with absent parents were limited.
- Mixed picture in terms of culture and identity being explored, understood and taken into account with the child protection and looked after process.

The full report will be completed by the 2nd October 2020 and the findings will be shared with the Service Manager and service co-ordinators with a view to agreeing an action plan in response to the audit findings.

Forward Plan:

- Following the mock inspection of CWD in August 2020 further thematic work will be undertaken (October to December 2020)
- Supervision – led by the principal social worker (to begin October 2020 and will be ongoing on a quarterly basis)
- Connected Person/SG (October/November 2020)
- Re-audit on permanency and pathway plans (November/December 2020)

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