Appendix 1

LEICESTERSHIRE COUNTY COUNCIL
CHILDREN & FAMILY SERVICES
Safeguarding & Improvement Unit

Independent Reviewing Officer (IRO) Service Annual Report 2016 -17

Content

1.0 Executive Summary

1.1 The IRO (Independent Reviewing Officer) has a statutory role to quality assure the care planning and review process for each child in care in order to ensure effective and improved care planning that achieves good outcomes. In Leicestershire, IROs take the same quality assurance approach as regards children subject to child protection conferences and child protection plans.

1.2 IROs independently oversee planning for children and have opportunity to challenge poor decisions and protect a child's interests, whilst ensuring their wishes and feelings are central and given full consideration.

1.3 This report considers the extent to which Leicestershire County Council has fulfilled its responsibilities to the children in its care and those subject to child protection planning for the period 1st April 2016 - 31st March 2017.

1.4 There are strengths, challenges and areas for improvement

1.5 For the purpose of this report, the term LAC (Looked After Child) will be used for statutory related references to children looked after by the local authority e.g. LAC Reviews and all other references will refer to children in care.

1.6 Strengths – What is Working Well?

- IROs have strong and meaningful relationships with a number of children and young people and continue to work hard at visiting and keeping in contact with them in between and prior to their reviews.

- Average performance for the year in relation to timeliness of LAC Reviews remains high at 99.4% as is the case for timeliness of Review Child Protection Conferences (100%) and Initial Child Protection Conferences (96.4%).

- Participation performance has improved further with 95.3% of children and young people participating in their LAC Review process in 2016-17 compared to 90.2% in 2015-16 and 92.5% in 2014-15.

- Ofsted, in their inspection of Leicestershire CFS during November/December 2016 made positive comments about the IRO Service in respect of timeliness of LAC Reviews and Participation

- Despite rising numbers of children in care and on child protection plans, the IRO Service has managed to improve their performance as regards timeliness of LAC Review records production and distribution. Timeliness as regards Child Protection Conference Records remains high.

- There has been a significant improvement in the timeliness and quality of the social workers report for the LAC review.

- An improved IRO challenge and escalation process is in place.with the introduction of the IRO Quality Assurance Alert. IRO managers attend the monthly CSC performance meetings, chaired by the Assistant Director to ensure that performance issues are addressed.

- As a result of Challenge meetings with the Assistant Director a number of situations have progressed more positively for individual children and young people.

- Communication with CAFCASS has been strengthened resulting in a better exchange of information between the IRO and the Chilfdren's Guardians..

- The IRO Service has addressed previous concerns about the use of multiple categories of risk in child protection planning and the approach now taken and embedded is in line with statistical neighbours, so supporting a more focused identification of presenting concerns for children.

- The percentage of Child Protection Plans which are repeats has been brought back in line with statistical neighbours, although this remains an area of focus for the service. Audits of cases take place to understand why a child has become the subject of a further period of child protection planning so we are able to learn and adapt practice.

- Positive feedback has been received from a number of other Local Authorities regarding Leicestershire's use of Signs of Safety Child Protection Conferences

- Positive development work as regards the departmental approach to working with children who display Harmful Sexual Behaviours (HSB)

1.7 Challenges – What are we worried about?

- IRO's have challenged the Local Authority on behalf of some children: and young people for whom the use of s20 voluntary accommodation is not assisting them in achieving permanency.

- IRO's have highlighted the need for a formal process to be put into place for oversight of Special Guardianship Order assessments and plans.

- Historically, the data in Leicestershire of numbers of children with a disability subject to a child protection plan is lower compared to national percentages.

- With numbers of children in care and on child protection plans rising it is sometimes a challenge to maintain high standards due to rising caseloads.

- It has not always been possible for the same IRO to chair every review for an individual child, but this is usually due to sickness absence.and therefore unavoidable.

- It is not always possible for IRO's to visit children placed at a distance between reviews or to track child protection cases between reviews..

- IRO's are not always challenging drift effectively enough, for example in progressing permanence plans. The Team Managers and Service Manager retain a strong overview of IRO and provide challenge in such cases.

- Practitioners and managers have not always consistently responded to QA alerts and or done this in a timely manner. IRO's have not always escalated concerns when a response is not satisfactory/or responded to, setting realistic timescales that guard against delay. These cases are brought to the attention of the Senior Management team, via the monthly performance meeting to ensure that performance issues are addressed.

- Harmful Sexual Behaviour development work (task and finish group) will need to continue to address bespoke training packages to staff across Leicestershire in order to develop practitioners knowledge and skills when working with Young People who present HSB.

1.8 Areas for Improvement – What needs to happen?

- To further develop practice of IRO's in achieving high quality child protection conferences. A continuing programme of input from skilled external trainers is in place through 2017/18. The impetus to sharpen delivery through best questions and family based plans with clear evidenced trajectories.

- Consideration of what needs to change to enable LAC Reviews to be more child focused following comments from a number of children and young people to Ofsted that they are too adult orientated. The service will work with the Children in Care Council and Participation workers to address this.

- IRO's to consistently use the escalation process to challenge drift/delay in achieving permanency for children and young people looked after.

- IRO's to continue to produce an analysis to SIU Team Managers in cases of repeat CP plans. This analysis to be used to develop practice and inform learning.

- IRO Service to implement new process to systematically review cases of children subject to CP plan for 9 months and consider exit plan that will achieve permanence.
- IRO Service to maintain good performance as regards timeliness of both initial and review child protection conferences.
- IRO Service to evidence consistency of chair for child protection conferences as far as possible.
- IRO Service to work with Business, Intelligence & Performance team to improve reporting capacity regarding partner agency attendance at child protection conferences and then use this data to inform best practice approach with partner agencies.
- A joint formal review of HSB (LSCB) procedures with Leicestershire, Leicester city and Rutland to be undertaken.

2.0 Introduction

2.1 The Independent Reviewing Officer (IRO) Service in Leicestershire is sited within the Safeguarding & Improvement Unit (SIU), part of Children's Social Care (CSC), which sits within the Children and Family Services (CFS). Whilst part of CSC, it remains independent of the line management of resources for children in care and the operational social work teams.

2.2 The configuration of the IRO Service in the Authority means that IRO's have responsibility for both child protection and children in care functions, through their role in child protection conferences and processes, Harmful Sexual Behaviours (HSB) work with children and young people and Looked After Reviews and care planning.

2.3 The IRO role is specifically concerned with improving performance and checking the quality of provision across these areas of work:

2.4 IRO's have a statutory role to quality assure the care planning and review process for each child in care and to ensure that his/her current wishes and feelings are central and given full consideration. The Children and Young Persons Act 2008 extended the IRO's responsibilities from monitoring the performance by the local authority of their functions in relation to a child's review to monitoring the performance by the local authority of their functions in relation to a child's case. The intention is that these changes enable the IRO to have an effective independent and holistic oversight of the child's case and ensure that the child's interests are protected throughout the care planning process. IROs take opportunity to challenge where decisions are not deemed to be in a child's best interest and an effective IRO service should therefore enable the local authority to achieve improved outcomes for

children. It is not the responsibility of the IRO to manage the case, supervise the social worker or devise the care plan.

2.5 In Leicestershire, IROs take the same quality assurance approach with children in care and children subject to child protection conferences and child protection plans. They chair child protection conferences and have oversight of child protection plans and the progress of such, challenging as appropriate when performance and practice concerns are identified as well as identifying good practice.

2.6 This report outlines the contribution made by the IRO Service in Leicestershire, to the quality assurance and improvement of services for children and young people in the care of the County Council and those subject to child protection conferences and plans during the year April 2016 to March 2017. It evaluates how effectively the service and the Local Authority have fulfilled their responsibilities to these children over this period; is an opportunity to pinpoint areas of good practice and those in need of development and improvement and highlights emerging themes and trends, providing information that contributes to the strategic and continuous improvement plans of the local authority.

2.7 For the purpose of this report, the term LAC (Looked After Child) will be used for statutory related references to children looked after by the local authority e.g. LAC Reviews and all other references will refer to children in care (CiC)

3.0 Context

3.1 In respect of the IRO role for children in care, the legal framework and statutory guidance that sets this out are the Care Planning, Placement and Case Review (England) Regulations 2010 (amended 2015) and the IRO Handbook 2010. *(Some consultation around review/update to the hand book has taken place over 2016-17 and the IRO Service in Leicestershire has contributed to this via its membership of regional IRO and IRO managers group, which has links to the National IRO Group – at the time of writing this report, the outcome is awaited)*

3.2 The Handbook requires an Annual Report to be written and is prescriptive as to content and format (which this report follows) and the expectation that the report is made available for scrutiny by the Corporate Parenting Board, as well as accessible as a public document.

3.3 The appointment of an IRO is a legal requirement under S118 of the Adoption and Children Act 2002, their role being to protect children's interests throughout the care planning process, ensure their voice is heard and challenge the local authority where needed in order to achieve best outcomes.

3.4 The regulations clearly specify circumstances when the local authority should consult with the IRO; when there are proposed significant changes to the care

plan including changes of placement, change of education plan or serious incident. IROs are a key part of decision making processes for children and young people's care and permanence planning.

3.5 Should IROs have concerns about the conduct of the local authority in relation to its provision for a child in care, they have the power to refer cases to the Children and Family Court Advisory and Support Service (CAFCASS)(section 26 of the 1989 Children Act as amended by the 2002 Act) who could consider bringing proceedings for breaches of the child's human rights, judicial review and other proceedings.

3.6 To support IROs in their challenge role, the statutory framework recognises the need for access to independent legal advice and supports that this should be in place.

3.7 As regards the IRO role for children subject to child protection conference/plan/processes, Working Together to Safeguard Children 2015 is the statutory guidance that governs the Local Safeguarding Children Board (LSCB) procedures to work within.

4.0 IRO Service

4.1 The siting of IROs within CSC is viewed by the service as beneficial overall as it enables IROs: to have a good understanding of the local authority and the context in which they operate; to have direct access to case records and therefore full information relating to a child's case; to build constructive working relationships with social work teams which aids good information sharing and partnerships and to have oversight of the strengths and needs of the department that in turn enables contributions to improvement activity for the benefit of children and young people.

4.2 Over 2016-17, the IRO Service has operated with two Team Managers to manage the team of IROs and the SIU Service Manager, who has lead responsibility for the IRO Service overall. The Service Manager reports to the Head of Service for Safeguarding. At the end of March 2017, the service had 12.66 FTE represented by 14 individual IROs. 12 members of staff are permanent employees and the other 2 are agency IROs currently contracted to the end of September 2017. One of the agency IROs is providing cover for an IRO who is seconded into one of the SIU team manager posts and the other agency IRO has been employed to help with sufficiency in the service pending recruitment to two new IRO posts for which funding has now been confirmed.

4.3 The issue of sufficiency within the IRO Service has been a concern for several years as reflected in previous annual reports and the service has been stretched and challenged to consistently deliver high standards and fulfil statutory requirements for some time. It is very pleasing that at the time of writing, confirmation of the growth bid for an additional 2 FTE IROs has been

given. Recruitment is underway for these additional permanent IROs. *(This will include recruitment to 0.8 FTE IRO post from a combination of 0.6 FTE post holder leaving the local authority at the end of June 2017 and another IRO also wanting to reduce their full time hours by 0.2 FTE)*

4.4 Caseloads for IROs (FTE) over 2016-17 have continued to be high and outside the recommended guidelines as per the IRO Handbook (50-70). The planned increase in capacity for the IRO Service will bring caseloads down . The current rising numbers of children in care and children subject to child protection plans will mean caseloads will be at the upper end of the recommended guidelines.

4.5 Collectively, the IRO service has many years of social work and management experience, professional expertise and knowledge across a number of areas which brings great benefit in their role working with children and families as well as an ability to offer consultation to the wider department. This includes but is not confined to:

- *HSB (Harmful Sexual Behaviours)*
- *Domestic Abuse Champion*
- *Neglect*
- *Children with disabilities and complex care needs*
- *Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs)*
- *Youth Offending*
- *Therapeutic social work*
- *Fostering, Adoption and Permanency*
- *Mental Health*
- *PREVENT & MAPPA*
- *Unaccompanied Asylum Seeking Children (UASC)*

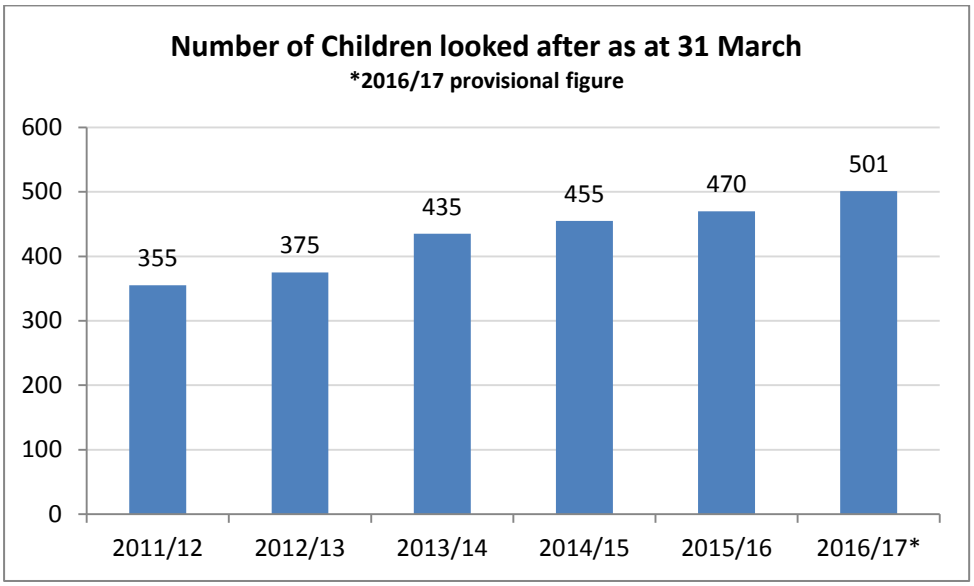
4.6 All IROs have had bespoke training in Signs of Safety, relevant to their role – this has included in depth residential training and several development days throughout the year that are continuing into 2017-18 as the department continues on its journey to embed the Signs of Safety methodology in its culture and practice. Some are practice leads and all these opportunities have meant a deepening of skill and the IRO Service really taking a lead and championing Signs of Safety developments across the department.

4.7 The expectations of IRO's are significant and the IRO Service in Leicestershire remains committed to delivering a high quality service.

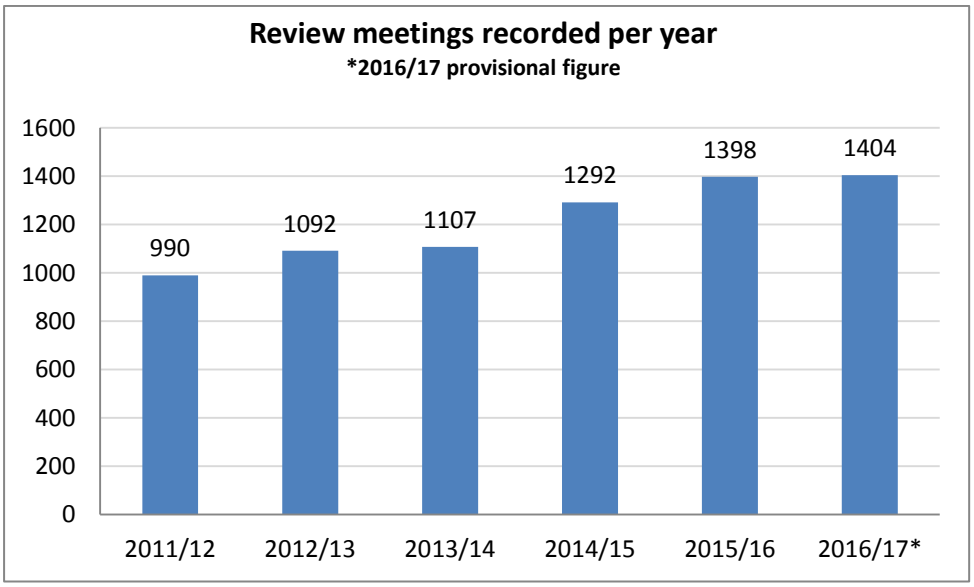
5.0 Independent Reviewing Officer Children in Care Service

5.1 As can be seen from the table below, the children in care population in Leicestershire has increased further over 2016-17, in keeping with a steady

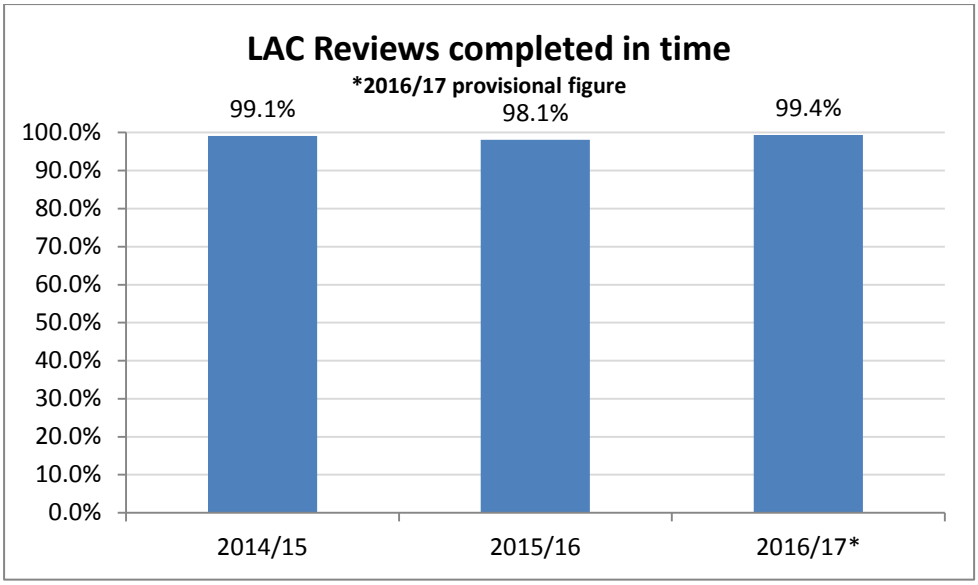
year on year increase over the last 6 years. This still remains lower than our statistical neighbour average.



5.2 The activity generated from this is reflected in the number of review meetings held for children between 1st April 2016 and end March 2017 which totalled 1404 – just slightly more than the previous year.



5.3 Performance in relation to timeliness of LAC Reviews remains very high as is reflected in the table below.



5.4 There were just 6 Reviews that did not take place in time over the year. Four of these were held in 2 parts (supports a flexible approach seeing the review as a process rather than just a meeting) and the date of the subsequent review calculated from part 2 rather than part 1 taking it out of date. This was an issue in the previous reporting period for one late LAC Review and a reminder was issued for admin and IROs. A further reminder has been sent in a bid to limit this moving forward.

The other 2 Reviews that did not take place in time were 28 day (Initial) Reviews and they were late as the IRO Service were not notified by the social work team that the child/young person had come into care until it was too late to hold the review in timescale. This was addressed at the time with the relevant managers.

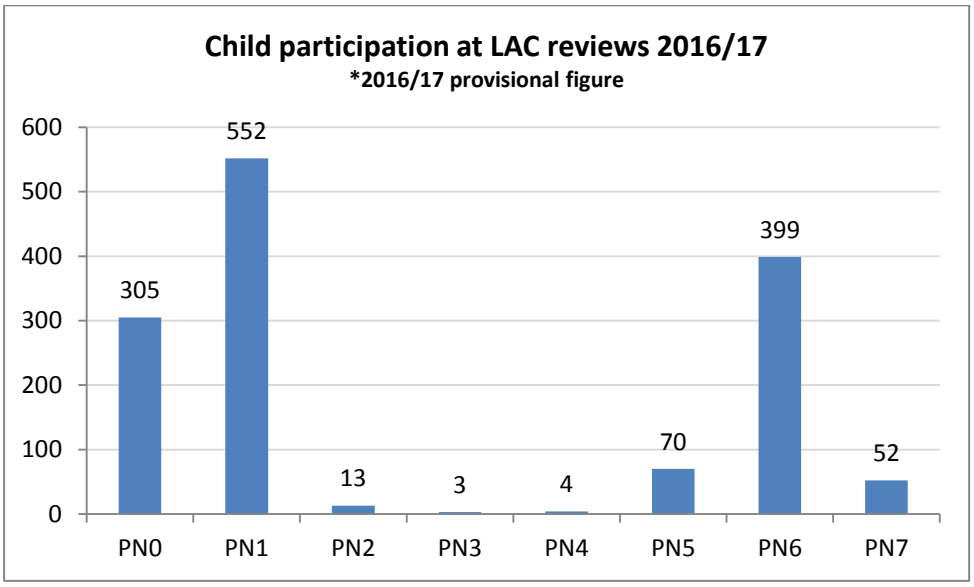
5.5 <u>Participation</u>

5.5.1 Children's voice needs to be central to their care plan and therefore their LAC Review, and engaging them in the process is essential in ensuring their voice has influence on their future.

5.5.2 Participation is defined across 7 different indicators:

PN1 Children who attend their reviews and speak for themselves;
PN2 Those who attend but communicate via an advocate;
PN3 Those who attend and convey their views non verbally;
PN4 Those who attend but don't contribute;
PN5 Children who do not attend but brief someone to speak on their behalf;
PN6 Do not attend but communicate their views by another method;
PN7 Those who do not attend/convey their views in any other way.
PN0 Represents children under the age of 4

5.5.3 The participation figures for this period are shown in the following table, and the overall percentage represents those children and young people aged 4 and over who communicated their views in some way, for their review.



5.5.4 Overall, 95.3% of children and young people participated in their LAC Review process in 2016-17, which is a pleasing and improved picture compared to 90.2% in 2015-16 and 92.5% in 2014-15. The largest category was where children attended their review and spoke for themselves There has been a determined focus by the IRO Service on engaging children and young people in reviews of their care plans over 2016-17 and the figures reflect the hard work in this respect

5.5.5 IROs have strong and meaningful relationships with a number of children and young people and continue to work hard at visiting and keeping in contact with them in between and prior to their reviews. Capacity in the service has continued to stretch IROs in this area of their responsibility, but despite this there are some very good practice examples of IROs engaging children and young people and seeking their views around their care plans and their meetings.

5.5.6 Ofsted, in their inspection of Leicestershire CFS during November/December 2016 found that,

"Statutory Reviews are timely, inclusive and well managed. IROs work hard to involve children in review processes appropriately…"

However, they also concluded that,

"…a number of children and young people spoken to describe them as too adult orientated."

Hence, there is clearly a need to take this on board and work further with children and young people to make this a more child focused arrangement. The IRO Service will look at how to make improvements with this over the year ahead.

5.6 LAC Review Records Production and Distribution

5.6.1 For some time, the IRO Service has experienced significant backlogs as regards production and therefore distribution of records of LAC Reviews. It was an issue that was captured in last year's annual report and has featured as a concern prior to this too. The IRO Service has worked really hard to address this over the reporting period and improvements have been increasingly evident since September 2016. Given continuing challenges with capacity, as well as rising children in care and child protection numbers it has not been possible for the service to completely eradicate the backlog but there has been a significant reduction as the following table shows:

End Sept 2016	112 out of timescale
End Oct 2016	51 out of timescale
End Nov 2016	10 out of timescale
End Jan 2017	45 out of timescale
End Feb 2017	35 out of timescale
End Mar 2017	44 out of timescale

As well as reducing numbers out of timescale, the length of time they are out of timescale by has reduced. In September 2016, there were some IROs who had records almost 6 months out of timescale; by the end of March 2017, this had reduced to maximum of 4-6 weeks out of timescale.

The IRO Service continues to have this issue high on the agenda and there is robust management oversight in place, with fortnightly monitoring and review taking place and where possible, workload tailored to try and balance the demand of the IRO caseloads and meet set timescales.

5.7 Social Work Reports for LAC Reviews

5.7.1 There has been a focused effort in the social work teams to improve performance as regards timeliness and quality of reports for LAC reviews; the social work report and updating assessment as well as the care plan. These are important reports as they are used by the IRO to consider what progress is being made for children and young people as regards their care and permanency planning and is the opportunity for the IRO to ensure plans are effective and helping to achieve best outcomes. There have been concerns about performance spanning several annual report periods and this has been reported as such in previous reports.

At the end of 2015-16 on average, 51.5% of reports had been available as required. At the end of March 2017, the average had increased to 56.3%

overall. It is important to note that during the year, performance has reached as high as 71.9% (Oct 2016) and remained in the 60's apart from Nov which was 59%.

There is clearly an upward trend and at the time of writing, this trend continues, with April 2017 reaching a high of 74.3% .

5.8 Permanence

5.8.1 A key learning theme from the Ofsted Inspection was in relation to achieving permanence for children and planning in this respect. They judged,

"…permanence planning is significantly weaker for those who are achieving permanence through options other than adoption."

As regards the role of the IRO in this, whereas they acknowledged,

"IROs challenge on behalf of children, when services are not meeting their needs, escalating cases to senior managers and to Cafcass…They are not however, always challenging drift effectively, for example, in progressing permanence plans."

They did note that IRO caseloads made it difficult to track cases between reviews as effectively as is needed but also that this was only in part and in addition to capacity there is clearly an improvement element to this for the IRO service. As part of a campaign across the department to address issues of concern around permanence, the IRO Service has started to take steps to make improvements including a learning and development session dedicated to knowledge and skills and understanding of permanence processes*, (took place March 2017)* but this will need to sit alongside progress in the wider department including developments in Permanence Panel as well as Quality Assurance & Audit Framework/Practice Standards, all of which form part of the CFS Continuous Improvement Plan 2017- 2020.

5.9 IRO Challenge & Escalation

5.9.1 One of the actions for the IRO Service arising from the 2015-16 Annual Report was to consider how IRO challenge could be more systematically captured and evidenced. A quality assurance template and process was devised and implemented in September 2016 – IRO Quality Assurance Alert.

5.9.2 For the period September 2016 to the end March 2017 there were 77 QA Alerts completed in relation to children in care. 16 for good practice and the remainder for concern.

5.9.3 **Good practice examples have noted:**

- Robust and timely care planning and actions to support such for some children.

- Robust and thorough assessment with child at centre leading to good outcome.
- Good quality reports
- Good quality relationship with young person
- Good quality Life Story work
- Focused social work practice to progress issues that were previously delayed and achieve positive outcome for young person concerned.

5.9.4 **Key areas of concern:**

- Timeliness/availability of reports/care plans for LAC reviews
- Drift & Delay/Actions not being progressed
- Quality of reports/assessments/plans and planning
- Statutory Visiting requirements
- Placement suitability/Placement Matching

5.9.5 The themes from the QA Alerts are fed into performance and practice forums across Children's Social Care and connect into the department's Quality Assurance Improvement Framework and improvement and development work follows. E.g. contribution to improved performance as regards timeliness of reports for LAC Reviews *(see section 5.7 above)*

5.9.7 Cases that are not progressing and are stuck/most concerning along with themes are taken into Challenge Meetings with the Assistant Director.

5.9.8 In addition, IROs have a mandate to liaise with Cafcass as well as seek independent legal advice when considered necessary/appropriate although these situations are few and far between, given the other challenge and dispute resolution layers that are in place in the local authority. There has been just one occasion over the reporting period where a referral for Independent Legal Advice was made and this helped to clarify the legal options regarding a child's placement with a connected carer and assist with timescales for progression of her plan for permanence.

5.10 Challenge Meetings – IROs, Assistant Director (AD) & Agency Decision Maker (ADM)

5.10.1 Changes in personnel at AD level over the reporting period meant there was a gap in these meetings being held between June 2016 and December 2016, at which point, with new permanent AD in post the arrangements were reviewed to include ADM in the meetings and started again on a monthly basis in March 2017.

5.10.2 Given the quality assurance role of the ADM, especially around achieving permanence for children, alongside the themes coming out of the ADM quality assurance learning and there being some overlap with themes identified by IROs it was felt prudent for ADM to be part of monthly challenge meetings also.

5.10.3 The issues/themes that have been considered in the 4 meetings include:

- Ofsted feedback re permanence
- Governance of Special Guardianship Order recommendations and quality assurance of support plans for SGOs and Adoption
- Social Work reports for LAC reviews not providing a thorough updating assessment.
- Plans not being outcome focused enough
- Quality of social work reports and assessments for Child Protection Conferences – challenges with less experienced staff in FRCD
- Quality of sibling assessment work
- Interpretation of use of connected placements at all cost
- Matching processes/considerations not being followed
- Drift & delay

5.10.4 As regards individual cases, as a result of oversight from the Challenge Meeting, a number of situations have progressed positively for children and young people yet some have taken longer to resolve given some of the layers of complexity. Learning is drawn from the presenting situations and actions taken, that contribute to improving practice.

5.10.5 As regards the themes fed into as well as arising from the Challenge Meetings, again, there are a number of workstreams/strands in place across the department, under the umbrella of the Continuous Improvement Plan that means all these areas are being picked up and progress is being made.

5.11 Cafcass

5.11.1 There continue to be good working relationships between the IRO Service and Cafcass Children's Guardians, at both IRO and Manager level despite some challenges to implementing the CAFCASS/IRO protocol in full. At the time of writing this report, new Service Managers and Family Court Advisers have been appointed in Cafcass and meetings have already taken place and are planned over the coming months that will support consistently strong and

effective working relationships between Children's Guardians and IROs moving forward for the benefit of those children subject to public law proceedings.

5.11.2 Admin systems have been strengthened in the SIU to support improved communication exchange/notification of involvement in care proceedings cases by Cafcass to IROs and vice versa as regards IRO allocations. In addition, admin support has been enlisted to strengthen the involvement of Children's Guardians in LAC reviews for children and young people and ensure they always have a copy of the LAC Review record if they were unable to attend and always have the dates of upcoming LAC Reviews.

5.12 Family Justice Board

5.12.1 The IRO Service has a direct connection into the Family Justice Board and the Performance Sub Group of the Board via IRO Service Manager and is able to keep abreast of issues arising from Public Law work that influences IRO practice and in turn their oversight of the practice/performance of the local authority as regards children subject to proceedings.

5.13.1 A key area they have contributed to over the reporting period, is the departmental review of children Looked After on a voluntary basis under S20 of the Children Act 1989 and the suitability or otherwise of S20 based on practice guidance from the Designated Family Judge in Leicester. IROs have raised several challenges about use of S20 and made recommendations accordingly as to the right way forward for some children and young people and their permanency arrangements.

5.13 Regional IRO Forums

5.13.1 The IRO Service has continued to engage in the East Midlands Regional IRO forums and has had the benefit of four tailored training and networking opportunities over 2016-17 covering areas on Immigration/UASC; Pathway Planning; Serious Case Reviews, Permanence, Youth Offending and Cafcass. These forums provide the chance to further IRO knowledge to support the role as well as share good practice across the region. They also connect in with the regional managers and national groups and assist in keeping up to date with developments and therefore supporting effective IRO services for children and young people.

5.13.2 One of the issues picked up from the Serious Case Review/Permanence session was that of a lack of a formal process in the local authority for oversight of Special Guardianship Order plans/assessments and a clear governance structure around this. The IRO service was able to bring this to the attention of Senior Managers and a working group has been set up looking to address this and look at the best way for more robust decision making processes/ratification of SGO when this is the proposed permanence option for children and young people in Leicestershire.

6.0 Child Protection Conference Service

6.1. Conference Activity

The number of Initial and Review Child Protection Conferences chaired over 2016/17 = 907, has increased compared to 817 over 2015/16. On average this represents approx.17 per week compared to approx. 15 per week and is reflective of increased child protection activity across children's social care on the whole, including increased numbers of children on child protection plans and increased numbers of care proceedings (this is a national picture also)

This is distributed as follows:

Type of Conference	**2016 -17**	**2015-16**
Initial	230	162
Initial Pre-birth	54	35
Initial/Pre-birth Initial	18	18
Initial Receiving-in	14	19
Initial Re-convened	0	0
1st Review	249	220
1st Review/Pre-birth Initial	1	-
1st Review/Initial	1	-
Review/Pre–birth Initial	6	4
Review/1st Review	10	3
Subsequent Review/Initial	1	-
Subsequent Review	323	356

6.2 Numbers of Child Protection Plans

Numbers of children subject to child protection plans measured at year end (31st March 2017) has increased significantly from the previous year:

2015-16	347
2016-17	434

6.3 Repeat Child Protection Plans

In the previous reporting period, it was identified that the rate of children becoming subject to a child protection plan for the second or subsequent time had risen markedly over an 18 month period to 30.5%, above those of statistical neighbours and a number of steps were needed to reduce this in order to ensure robust and lasting outcomes for this cohort of children.

To understand the issues, a thematic and senior management audit on repeat plans was undertaken in March 2016, followed by a staff conference and discussions at the LSCB. IROs contributed to the audit work by undertaking

analysis of each case where the children had been previously subject to a Child Protection Plan, identifying themes and learning, to better inform practice.

One of the conclusions from this work was the need to reinforce the procedures and oversight provided in the step-down phase from Child Protection to Child in Need services. In particular it was noted there was a need to pay more focused attention to those cases where the 'toxic trio' of domestic violence, substance misuse and parental mental health problems are factors and to engage collaboratively with partners in this respect.

Children in Need practice guidance was developed and issued and a number of measures put into place to ensure children receive the right service at the right time, reducing the need for repeat CP Plans.

The outturn at the end of 2016/17 was an improved average of 18.7%, in line with statistical neighbours (18.1%). The Ofsted Inspection of Children's Services in Leicestershire (14th November 2016 – 8th December 2016) recognised the work undertaken within the Authority and, "…*strong emphasis on delivering sustainable progress for children, before child protection plans are ended…"*

The department has carefully considered what has worked well to contribute to this improvement and is using this learning to ensure this progress is sustained moving forward. The role of the IRO Conference Chair has been significant in this respect and robust practice will continue that will encompass:

- Plans being of good quality, SMART and outcome focused
- All elements of the CP plan are effectively reviewed and there is evidence of progress being made and sustained – effective core group activity
- Safety goals have been achieved
- There is evidence of management oversight as regards assessments and recommendations to end plans
- IRO's facilitate the discussion regarding CIN plans when they are an outcome of conference to ensure plans are robust.
- IRO's to continue to provide an analysis to SIU Team Managers in repeat plan situations

6.4 Plans Ending

Linked with the above, it was evident at certain points over 2016/17 that performance data was showing significant numbers of Child Protection Plans ending at the first review – less than 3 months on a plan. Some analysis was undertaken that established that in the majority of cases there was a safe

rationale, largely due to the child(ren) becoming subject to legal proceedings and therefore no longer needing a child protection plan in addition.

6.5 Length of Plans

Just as those plans that end after a very short period of time need to be scrutinised, so too do those plans that have been in place for lengthy periods of time as this calls into question the effectiveness of such intervention and indeed how robust the approach is in bringing about lasting change/permanence for children and young people.

Whereas Ofsted were complimentary of child protection conference chairs in their review of child protection plans for children and young people *(See 6.7)* they also noted that, *"…in a small minority of cases, independent review is not challenging and proactive enough to ensure that plans progress effectively."*

At the time of writing, a piece of audit work is underway reviewing 6 children's cases that have been on a plan for over 2 years. The work is being undertaken jointly by IROs and Quality Assurance and Auditing Lead and includes consideration of exit planning. The learning will be established and actions progressed to influence any practice and process changes/improvements that are needed.

In addition, a new process to systematically review cases of children subject to CP plan for over 9 months and consider exit planning is in the early planning stages with the intention of this becoming embedded into IRO service practice over 2017/18.

6.5 CP Plan Categories of Risk

It was reported in the previous period that steps had been taken with the IRO Conference Chairs, to address the then significant level of multiple categories of risk used in CP plans. As can be seen from the 2015-16 table below, the data was showing an approach at odds with that of statistical neighbours/national picture (which is @ 8%) and there was a concern that use of multiple categories of risk was getting in the way of being clear as to need from a departmental commissioning perspective and importantly was making it less clear for children and families as to the primary presenting concerns. This lack of clarity was not in keeping with Signs of Safety methodology.

Date	No of CP Plans	No of multiple categories	% multiple categories
End Q1 2015-16	343	156	45.5
End Q2 2015-16	327	169	51.7
End Q3 2015-16	339	93	27.4
End Q4 2015-16	347	31	8.9

In the previous period there were observed to be positive results in Q4 (2015-16) from a more rigorous approach taken by IRO Conference Chairs and this has become embedded in practice over 2016/17 as demonstrated by following table. When looking at the pattern of multiple categories there are no more than 2 used, with the prevalent combination being Emotional & Physical harm followed by Emotional & Neglect.

Date	No of CP Plans	No of multiple categories	% multiple categories
End Q1 2016-17	347	23	6.6
End Q2 2016-17	374	32	8.5
End Q3 2016-17	419	34	8.1
End Q4 2016-17	434	20	4.6

6.6 Child Characteristics

The age range and gender of children subject to a Child Protection Plan remains a similar distribution as reported in previous periods with the majority of children aged 0-4 (37.6%) then 5-9 (30.7%) followed by 10-15 (22.6%), with unborn (6.7%) and then those aged 16+ (2.4%).

The ethnic profile of children subject to CP plans also remains fairly consistent to previous years with 86% of children being of White origin and the remaining 14% distributed across BME backgrounds with those of Asian/Asian British and Mixed origin accounting for most.

Historically, the data in Leicestershire of numbers of children with a disability subject to a child protection plan is lower compared to national percentages. Work has taken place over the reporting period to understand the factors influencing this as well as ensure most accurate reporting/recording of disability. This has resulted in an increased percentage of children reported to have a disability subject to a plan but there is still scope for further improvement/accuracy and this is being developed with involvement from the LSCB as well as Disabled Children's Service.

6.7 Conference Performance

Over this period, considering the total numbers of conferences taking place over the year (907), only 19 (2%) have been problematic from the perspective of having to be stood down on the day and rearranged. Although this is a very small percentage, the impact for all concerned, especially the families is acknowledged and when this happens, any learning is considered and avoidable issues are taken up by the IRO Service; e.g. lack of agency attendance is taken up with agency leads.

The main reasons for conferences not being able to go ahead at the time were lack of agency attendance (7 – this included 2 where the transferring authority did not attend as expected); incomplete information in the assessment with report being late and/or insufficient preparation for family (4); Social Worker ill and no replacement available (3); lack of interpreter (2); family member behaviour deteriorating to extent that meeting could not safely continue (2); social worker rushed to hospital (1)

The timeliness of Review Conferences over the period was excellent with 100% convened within statutory requirements and that for Initial Child Protection Conferences also very good at 96.4% at the year-end – a significant improvement from 83% at year-end 2015/16.

Ofsted during their Inspection in Nov/Dec 2016 commented positively that,

"…*Child Protection Plans are mostly reviewed effectively by child focused independent reviewing officers (IROs) and have strong multi-agency attendance and contribution. Timeliness has improved and a very high proportion of initial child protection conferences are held within required timescales."*

6.8 Conference Records

Distribution of child protection conference records is very timely and has seen good performance over the reporting period, largely as a result of a collaborative approach with the team that provides administrative support for conferences, with the development and introduction of a revised template that captures a summary of significant points identified in the conference and is Signs of Safety congruent.

The majority of records, along with a copy of the Child Protection Plan are distributed within 5-10 (max.) working days of the conference taking place. Significantly, in addition, a typed copy of the mapping (the information completed on the whiteboard in the conference) is given to all attendees to take away with them at the end of the conference so everyone, including families, has a clear record of the strengths, concerns and what needs to happen to address the risk of harm to the children and young people concerned.

It is important to note the contribution from the clerks whose professional skill and diligence have ensured a high standard of record

The above performance is positive in light of learning identified for the Conference Chairs Service from a Serious Case Review which highlighted some concern that in previous periods, capacity issues in the SIU led to inconsistency of chairing and quality and timeliness of records being compromised. The quality and timeliness of records issue has been addressed and this is no longer a continuing concern.

The service strives to provide the same IRO chair for all the conferences for a family but this has been a particular challenge over the reporting period that has not always been achieved due to pressure points in capacity within the service at different times. Realistically there will always be times mainly due to sickness that a change of chair will be needed but on the whole, the additional IRO posts being recruited to will make it more possible to deliver this standard moving forward. In situations where it is not possible to provide the same person, those picking up the responsibility endeavour to spend additional preparation time reviewing previous records and liaising with allocated social workers so they are best prepared and in the best position to provide a good service.

6.9 Social Work Conference Reports

In line with LSCB procedures, parents should receive the report for an Initial Conference at least 2 working days in advance and it should be with the chair 1 working day in advance. The report for a Review Conference is to be with the parent and the chair at least 3 working days in advance.

Parents need time to digest and consider the information contained in social work reports and enter the child protection conference feeling clear and prepared. The Signs of Safety ethos of working openly and transparently with families supports this approach and without it families are left feeling anxious and unprepared which does not make for good working relationships and does not support good quality child protection conferences.

Performance in this area has been a challenge for practitioners for some time; it was highlighted as a concern in last year's annual report and has been the focus of improvement work in the department over 2016/17.

There has been some evidence of improvement compared to 2015/16: At the end of the reporting period, performance for initial conferences stood at 49.4% and for review conferences 42.3%. There is still significant room for further improvement but it is important to note that fewer parents are receiving reports on the day of conference than previously.

6.10 Consultation

The IRO conference chairs and managers continue to offer consultation to the locality social work teams in situations that might be more complex/have a number of complicating factors that could impact negatively on a smooth child protection conference process. When this has been taken up, it has often resulted in the preparation for conference being more effective, particularly with planning for conferences with multiple parents.

6.11 Agency Contribution & Participation

It is expected and clearly outlined in LSCB procedures that agency representatives should provide accurate and concise information to conference, in the agreed format, in advance of the conference.

One of the areas of work to be taken forward over 2016/17 was to improve the quality of information/reports to conference by GPs.

A piece of audit work was undertaken by the Clinical Commissioning Group (CCG) lead, to get a sense of GP report provision for conferences and format used and an LSCB Task & Finish group has been set up to review the format and align with SoS. This work is not complete and is to be continued into the next period (2017-18).

The Police have revised their attendance and report contribution to conferences in response to resources available balanced against ensuring required information is available for conferences. It is a challenge for Initial Conferences when they are booked with limited notice (which can be for a variety of reasons not always in the SIU control) and there are occasions when information is not as full as it needs to be. The police and CFS are alive to the issues this creates and continue to work together to ensure information is available as needed.

6.12 Implementation of Signs of Safety (SoS) Child Protection Conferences

Since July 2015, all Child Protection Conferences in Leicestershire have been delivered using the Signs of Safety (SoS) approach and IROs continue to develop and improve their skill through bespoke thematic training as well as attendance and contribution to Practice Lead Workshops. There have been

periods where practice observations have been undertaken by the SIU Team Manager who has led on the implementation of Signs of Safety in Child Protection Conferences and the learning has been fed into a combination of individual supervision sessions, team meeting practice sessions as well as the IRO development practice days with the SoS trainer.

To date the audit/practice observations referenced above, have not been undertaken in a systematic way as part of a regular cycle/programme but this is set to change over 2017/18, in line with the improvements planned and taking place across the wider department as part of the Ofsted Action Plan, in particular the development of a new audit framework/model and programme.

Under the previous audit programme, Quarter 2 of this reporting period saw a targeted audit undertaken of assessments/reports to conference along with the CP plan produced. The learning for the SIU and the IRO's was informative. Whereas there was some evidence of some good quality CP plans that were SMART, it was not a consistent pattern. The main challenge was to ensure that all CP plans identified a contingency plan, and that all plans set out clear outcome focused objectives with timescales. Both of these issues formed part of the work with IRO's in the proposed Development Day, and will continue to be supported moving into the next period as it was an issue that Ofsted identified also,

"…plans are not always sufficiently clear about what parents need to do to change and by when…"

Work on practice standards as part of the departmental improvement plan will assist greatly in taking this forward over 2017/18.

6.12.1 Feedback

The IROs have provided direct support and advice to SW on the SoS approach. This has been welcomed, as evidenced from the communications received from SWs and TMs in supporting case discussions and skilfully managing the CPCs.

"This conference was a very difficult one due to mother's mental health. D was very empathetic and kept the conference focused, which was an extremely difficult task. D was very person centred and showed the upmost respect to mother, but remaining focused on the child."

LB – Social Worker LCC

"Just wanted you to know that the conference this morning was really good and I felt made everyone think about how to get to the right decision… just wanted to say well done!"

SM – Team Manager LCC

"D and I wanted to let you know that R had a very difficult RCPC with D where the professionals were quite interesting in their views. D felt R managed this really well and we wanted to give this feedback to R."

LB – Team Manager LCC

There has been continued collaboration and support with other Local Authorities who were embarking on the implementation of SoS approach to CPCs. This has included our neighbouring authorities Leicester City & Rutland, along with Cumbria, Lincolnshire, Sandwell, Solihull and Nottinghamshire. The feedback from these has been very positive, with praise being received for the skill and professionalism of the IRO.

"…just to let you know that our implementation of the SOS conference processes has gone really well.

We gathered feedback during the early phase of this process and this really helped our evaluation.

Just to say a very clear thank you to you and your team for allowing us to learn from your good practice.

IRO Service - Solihull

I just wanted to say thank you to you both for allowing me to attend the conference yesterday.

I was impressed by H's skill as a chair and it was very interesting to see how Leicestershire have implemented the Signs of Safety Model.

IRO Service – Nottinghamshire

"Thank you very much for the shadowing opportunity…I'm really impressed by the process and the way you managed the conferences. I really like the dynamic nature of the meetings and the involvement of family members…

It was good to see the SW coming to the meeting with a Danger Statement, Genogram, Safety Goals and Direct Work with children which was discussed during the meeting. Also good to see a wall chart being typed up and copies given to everyone at the end of the meeting…"

IRO Service – Cumbria

6.12.2 Next Steps

It is the ambition of the IRO CP Service to further develop practice in achieving high quality child protection conferences. To this end a continuing programme of input from skilled external trainers is in place through 2017-18. The impetus will be to sharpen delivery through best questions, and family based plans (with clear evidenced trajectories) based on best principles from the SoS methodology.

This will be underpinned by developments arising from the implementation of England Innovation Project (EIP) 2 and the service will continue to grow and learn as part of this regional and national network.

6.13 Challenges & Escalation

As referenced in the introduction of this report, the IRO CP Service has a quality assurance role in identifying areas of concern in child protection practice and undertaking challenge where it is required. In September 2016, as referenced in section 5.9, a quality assurance template – IRO Quality Assurance Alert - was devised and implemented as a means of formally and systematically capturing and evidencing IRO activity in this respect. It wasn't that challenge had not been taking place prior to this but there was a need for a clearer and more consistent process that could be reported on and provide information about individual impact as well as themes to feed learning and service improvement.

It is important to note that the QA Alert is not just about drawing out concerns but highlighting good practice also.

For the period Sept 16 – end March 2017, there were 13 Good Practice Alerts raised and 72 for concern. Monthly overview reports have started to be produced and shared with departmental senior management meetings (SMT) and fed into performance meetings. There is a need moving forward to ensure that these are available in a timely and consistent manner so the learning is up to date and relevant for practitioners, teams and service areas.

Good practice examples have noted:

- Some practitioners producing good quality timely social work reports to conference
- Good quality, focused social work practice that meant plans were progressed in a timely and robust manner, work with families brought

about change needed and children safeguarded effectively with improved outcomes as a result.

Concerns:

The table below captures the key areas. NB this includes instances of multiple concerns on the same QA Alert.

Drift/Delay	8
Timeliness of report	13
Other	18
Quality of report/assessment/plan	7
Core Group	16
Statutory Visits not on time/completed	7
Lack of permanency plan	2
Length on Plan	1

Timescales:

Practitioners and Managers have not always responded to QA Alerts and/or done this in a timely manner and IROs have not always consistently and robustly escalated concerns when a response is not satisfactory/not responded to, setting realistic timescales that guard against delay. Some cases have been escalated unnecessarily as a result of delayed responses from some managers, not because of complexity.

This is an area that has seen some improvement since the issue has been raised but there is a need for this to improve further moving forward.

IRO QA Alert Activity:

It has been useful through the overview reports to get a sense of the degree to which IROs are using the QA Alert as required and it was identified in the earlier stages of implementation that there were some IROs who were not using it as expected. This was addressed with those concerned and a change in approach was then evident. However, this continues to be monitored and reviewed across all IROs as this needs to be fully embedded into the routine practice of the service as the Quality Assurance role of IROs gains yet further strength.

6.14 Appeals/Complaints

Seven young people appealed the decision to make them subject of a CP Plan in this period, supported by the Children's Rights Officer for Child Protection.

(There is a separate Annual report of the Children's Rights Officers that goes into more detail and covers children's participation and voice in child protection conferences)

None of the appeals were upheld, yet each appeal received a full written response from the IRO who chaired the meeting. On one occasion the IRO arranged a face to face meeting with the young people in conjunction with the Children's Rights Officer. In all of these appeals the young people expressed their thanks for the response, and none wished to take the matter further (although were informed what steps they could take should they wish to do so).

There were two appeals made by parents/carers in this period. One was resolved at Stage 1 and the other progressed to Stage 2 but the parent then disengaged from the process.

There was one complaint from a professional regarding an IRO's management of part of a Child Protection Conference. The issue related to that professional only, and no other attendee felt the meeting had been handled in an unprofessional manner. There was a sensitive approach with the individual concerned through a face to face meeting followed by a letter and the matter was resolved.

7.0 Harmful Sexual Behaviour (formally known as CUSAB – Children Using Sexually Abusive Behaviour)

7.1 The safeguarding lead for Harmful Sexual Behaviour (HSB), is one of the Team Managers in the SIU and over 2016-17, she has been involved in a significant amount of development work that has been undertaken across Children and Family Services (CFS).

A task and finish group was established to develop the operational response to HSB, made up of key managers and practitioners from CFS including HSB safeguarding lead and specialist therapeutic worker, along with Police Child Abuse & Investigation Unit (CAIU) and Learning & Development (L&D) representatives. The group highlighted a number of areas requiring attention; in the main:

- Workforce/agency understanding, knowledge and identification of HSB concerns including effective use of HSB procedures in order to provide appropriate response to presenting situations.

- Response to National developments

  Moving forward into 2017-18, the group will be chaired by the Head of Service Safeguarding , Improvement and Quality Assurance and will focus on the future developments at a strategic level. A sub group continues to address the training and developmental gaps across the work force.

7.2 Strengths - What's working well:

7.2.1 LCC in the context of National Developments

The NSPCC and National Institute Centre of Excellence (NICE) both published guidance in 2016 emphasising the use of changed terminology from 'Children Using Sexually Abusive Behaviours,' to 'Harmful Sexual Behaviours.' This is to reflect the impact of the behaviour rather than the person.

The Notion of 'Harmful Sexual Behaviour' has a duel concept of harm to others and harm to self. Choosing the right terminology is important to avoid stigmatisation of children and young people. It is also important that descriptions of HSB are contextualised as regards age appropriate healthy sexual behaviour among children and young people.

The task and finish group decided a need for LCC CFS to move forward in line with the national picture and recent guidance and adopt a change to what terminology and language is used in the department. This has been agreed and the term HSB is being used instead of CUSAB.

7.2.2 Training & Workforce Development

Staff understanding of HSB thresholds and procedures has needed further development and it was recognised that there were different levels of training needs across the staff group; basic training and then more advanced training. Brook's traffic light tool basic training for all CFS staff, AIMS 2 training for experienced qualified Social Workers, AIMS for managers supervising cases of HSB and 'good lives intervention model' for those practitioners who have completed the AIMS 2.

The charity 'Brook' has a sexual behaviour traffic light tool which can be used to distinguish different types of sexual behaviours at different age levels. It is also important to indicate what constitutes HSB when it's displayed by

children or YP with a learning difficulty or developmental disorder which may have inhibited their sexual maturity.

The task and finish group undertook train the trainer in Brook traffic light tool and have rolled out in house training sessions, made available for all workers across CFS.

AIMS 2 is a nationally recognised risk assessment tool for male children over the age of 10 years who are displaying HSB. The risk assessment assists practitioners to identify a suitable intervention programme. Prior to Jan 2017 only 2 workers in CFS were trained by AIMS 2 (HSB Lead in safeguarding and Specialist Therapeutic SW). Risk Assessments were mostly being completed by YOS workers when there was already an allocated YOS worker. This left a gap in knowledge and skills within CFS to risk assess young people who were displaying HSB but were not involved/met the threshold for YOS. In Jan 2017, 10 qualified and experienced social workers across the service were trained in AIMS 2 alongside a further 11 YOS workers and 1 Detective Sergeant (DS) from CAIU(police).

AIMS training for Managers across CFS went ahead in March and April 2017 for all relevant managers as well as police. This training is designed to support line managers who supervise workers undertaking the AIMS 2 and intervention programmes with children and young people who display HSB. Unfortunately there were some parts of the service where they were not able to attend which left a gap in knowledge. Some consideration is now being given to providing bespoke 1 day training to the managers that were not able to attend which will give them the detail needed to understand thresholds of HSB and knowledge to support the workers in identifying appropriate support packages when completing Assessments.

The HSB lead in Safeguarding and the DS (CAIU) have undertaken two briefing sessions to CAIU sergeants on HSB thresholds, procedures and training outcomes to enhance the police understanding of CFS responsibilities towards children and YP who display HSB.

7.3 Challenges - What are we worried about:

7.3.1 <u>HSB Procedures</u>

The HSB lead and HSB therapeutic social worker has met with the Principle Social Worker in Leicester City CFS to discuss a joint review of the LSCB Children Using Abusive Behaviours procedures. It is agreed that the terminology needs to be reviewed formally in respect of the procedure as does the procedure itself. The police CAIU have identified that City and County CFS despite having a joint procedure work in different ways when it

comes to thresholds, strategy meetings, HSB meetings and intervention. Leicester City CFS are also in the process of HSB development.

Under the guide of the chair and strategic lead for the HSB development group, there is a proposal in place to jointly review and update the LSCB procedures for LLR; make them 'fit for purpose' and link to improving frontline staff knowledge of them. The expectation is that there will be a consistent approach by front line staff and managers which will result in better outcomes for children who are victims of and those children who use Harmful Sexual Behaviours.

7.3.2 Harmful Sexual Behaviour Meetings

Over the reporting period, the HSB lead has received 41 referrals. From these, 21 HSB meetings were held and the other 20 did not meet the criteria. 13 of the children subject to a HSB meeting were children in care. All 41 children were reported to be of White/British ethnicity which raises the question about under representation of children with other ethnicities.

In the previous reporting period, 35 HSB meetings were chaired by the HSB Lead. At this time, Family Action – an external organisation - were undertaking all direct work and intervention for children and young people referred as a result of recommendations from the HSB meeting. In Nov 2015 the commissioning of therapeutic intervention through Family Action ceased and intervention work has since been provided in-house, delivered by the specialist therapeutic worker.

There needed to be a revision of thresholds for intervention at this point and it changed from all children who displayed some harmful sexual behaviour including those needing post sexual abuse intervention to those who are identified as displaying Red/Amber behaviours in the context of the Brook sexual behaviour traffic light tool.

For children who were referred but did not meet the Red/Amber threshold, recommendations from the HSB meeting looked to either basic intervention from the allocated social worker or referral to Family Action for post sexual abuse therapy - a noticeable number of children being referred for HSB appear to have a history of being sexually abused in earlier childhood.

From analysis of the cases that are referred to the HSB lead for a meeting and intervention, there are indicators that there has been a lack of understanding by social workers and managers as regards HSB and related pathways. A more recent snapshot audit undertaken at the beginning of the new reporting period, showed that of 15 referrals received between Feb- May 2017, only 3 met the thresholds for a HSB meeting, 3 required basic

intervention from an allocated social worker, 6 needed a referral for post sexual abuse due to evidence that they had been sexually abused in the past and the remaining 3 required no intervention.

It is therefore considered that there is a clear need for further training and development on top of what has been provided so far, as well as the revision of the procedures to assist with understanding of thresholds..

7.3.3 HSB lead role

The HSB lead role has sat in SIU for the past 10 years, this has consisted of x1 IRO (currently seconded to Team Manager role in the SIU) chairing HSB meetings and offering consultation to the CFS staff group.

Prior to November 2015, when Family Action provided all intervention and consultations to social workers, the role mostly consisted of chairing meetings and providing a record of the risk assessment from the meeting as a referral to Family Action.

Post Nov 2015, the impact on the HSB lead has been significant and the role has needed to expand accordingly. It now encompasses more consultation around thresholds, processes and procedures; chairing HSB meetings and providing a record of the meeting; quality assurance activity and other activities around development work and input to training and workforce development. It is apparent that the HSB lead role needs to be reviewed to ensure that the capacity to offer an effective service remains paramount.This review has started and some initial proposals are being developed and actioned.

7.4 Areas for improvement - What needs to happen:

Future departmental training continues to be critical to the agenda in order to improve outcomes for children and young people displaying HSB. As highlighted, a significant proportion of CFS staff are not as familiar with the HSB procedures and thresholds as they need to be in their role.

The HSB task and finish group have identified that the lack of understanding means that children are not always identified in a timely way and on some occasions have been left without a safe care plan in place. Schools and Colleges as a result have isolated children as a way of managing their behaviours rather than ensuring their needs are met and robust risk assessments are in place. These cases have been followed up and any gaps have been filled; the messages and learning from such feeds the improvement agenda for HSB developments.

The future training programme has been identified as below and will be presented to the Senior Management Team when the details are finalised:

(i) Brooks Traffic Light Tool training to continue to be rolled out to all CFS workers

(ii) A further AIMS 2 training has been identified and currently 18 qualified social workers in CFS have been earmarked to attend this course, this includes 2 IRO's to support the HSB lead.

(iii) Bespoke HSB training for First Response team managers

(iv) Training for all CFS staff regarding procedures/basic intervention work

(v) Good lives Model intervention training for Social Workers/YOS who have undertaken AIMS 2

The task and finish group will also continue to focus on the strategic developments including:

(vi) Joint review and update of LLR LSCB procedures for HSB to include changes to procedures/process and language.

(vii) Staff group training/briefing on updated procedures to be undertaken.

(viii) Link with Safeguarding in Education development officer to ensure training and advice/consultation to local schools/colleges Designated Safeguarding Leads (DSL) is up to date and in line with HSB developments

(ix) Review the resilience around the role of HSB lead and where best this role sits in the future in order to deliver the best possible service and support good outcomes.

(x) Review of Family Action contract re Post Sexual Abuse intervention with Children and Young people in Leicestershire to ensure they are meeting the terms of the contract.

1.1 Recommendations for 2017-18

(i) IRO Service to draw up implementation plan and present to SMT, in respect of any changes arising from the consultation/revision of the IRO Handbook.

(ii) This Annual Report to be tabled for CFS Overview and Scrutiny Committee on the 11th September 2017 and then Corporate Parenting Board 26th September 2017.

(iii) The IRO Service to progress the recruitment of additional permanent IROs following growth bid agreement and to seek to reduce IRO caseloads accordingly.

(iv) All IROs to be trained in Signs of Safety methodology and dedicated training and development practice lead sessions for IROs to be committed to over 2017-18. IROs to continue to demonstrate fidelity to Signs of Safety Methodology and deepen their skill and practice using these opportunities

(v) IRO Service to seek to improve the participation of children and young people with additional communication needs in their LAC Review/process – this will be taken forward in conjunction with Participation Officer for Children in Care and will include review of current commissioned service to ensure provision is fit for purpose.

(vi) IRO Service to seek to make LAC Reviews more child focused, less adult orientated and gain feedback from children and young people as to their experience in this respect with a view to evidencing an improving picture

(vii) IRO Service/SIU Admin to evidence improved performance over 2017-18 as regards timeliness of production and distribution of LAC Review records.

(viii) Operational teams to evidence improved and sustained performance over 2017-18 as regards timeliness/availability and quality of social work reports, updating assessments and plans for LAC Reviews and child protection conferences.

(ix) IROs to be fully and consistently effective in challenging drift and delay. The IRO Service needs to evidence more robust and timely challenge where drift and delay is a feature in a child's circumstances.

(x) All IROs need to ensure they raise QA Alerts when required to do so – new monitoring form being built into Mosaic (new recording system) will support a more robust approach.

(xi) IRO Service to provide regular and timely IRO QA Alert overview reports – quarterly – to SMT and Performance Meetings.

(xii) Operational teams to ensure practitioners and managers respond and in a timely manner to IRO QA Alerts

(xiii) IRO Service to work closely with Cafcass over 2017-18 to ensure full and consistent application of the IRO/Cafcass Protocol –

particular emphasis on improving the instances of formal handover from Children's Guardian to IRO at the conclusion of proceedings and participation of Children's Guardians in LAC Reviews.

(xiv) IRO Service to continue to contribute to robust and focused practice to ensure low instances of repeat child protection plans for children – this will include analysis of cases to draw out themes and learning.

(xv) IRO Service to implement new process to systematically review cases of children subject to CP plan for 9 months and consider exit plan that will achieve permanence.

(xvi) IRO Service to maintain good performance as regards timeliness of both initial and review child protection conferences.

(xvii) IRO Service to evidence consistency of chair for child protection conferences as far as possible.

(xviii) IRO Service to work with Business, Intelligence & Performance team to improve reporting capacity regarding partner agency attendance at child protection conferences and then use this data to inform best practice approach with partner agencies.

(xix) HSB Training Programme as outlined in Section 7.4 points (i) – (v) to be finalised, presented to SMT and implemented in agreed timescale.

(xx) HSB Task & Finish Group to take forward strategic developments outlined in Section 7.4 points (vi) – (x)

Judith Jones
Service Manager

Rebecca Watson & Martin Wilson
Team Managers

Safeguarding & Improvement Unit
August 2017

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