Appendix F

Appendix F – Story Boards 2017-2018 for IRO Children in Care and IRO Child Protection Conference Service

QAiF Quality Assurance & Improvement Framework

IRO Service - Children in Care March 2017

Leicestershire County Council

Where were we?

- IRO Service has developed since late 2014 to a position of stronger standing in the CFS with a strengthened approach to challenge in respect of supporting good care planning and outcomes for children. However, there was a need for further strengthening and consistency as regards the challenge and quality assurance approach from the IRO Service.
- Wealth of experience, expertise and knowledge across the IRO Service with ability to offer consultation in a number of lead areas including Children Using Harmful Sexual Behaviour, Mental Health, Youth Offending/Remand/Secure Accommodation. IROs trained in Signs of Safety and championing this approach in their role .
- Meaningful relationships between IROs and children and young people with IROs in contact with and visiting children including those placed at a distance.
- Strong performance as regards timeliness of LAC Reviews and children's participation
- IRO Service Regional and National links and training and development opportunities.
- Significant backlog of decisions from LAC Reviews

What have we done?

- Introduced more robust systems and management oversight to support IROs in timely turnaround of LAC Review decisions
- Developed IRO Quality Assurance Alert & IRO Challenge activity including challenge meetings between the IRO Service managers and Assistant Director.
- Provision of bespoke training and development opportunities through Regional IRO Training Workshops
- Developed and maintained links with Cafcass and representation on Family Justice Board and Performance sub-group; Use of IRO view template in court, IRO Cafcass protocol and independent legal advice has provided opportunity for influence in care proceedings.

What else do we need to do?

- Development of an evaluation tool to gain feedback about the quality and experience for young people of their Review and the IRO Service.
- Improved use of data to establish evidence of IRO activity on child's case and links with QA in capturing contact and visits.
- Further training and development work with IROs alongside that across CFS to ensure a consistent and robust approach to care and permanence planning for every child with strengthened management oversight processes – avoid drift and delay
- Sustain progress as regards timely turnaround of decisions from LAC Reviews
- Continue to refine and enhance QA Alert process ensuring consistent and full use by IROs; capture the difference this is making/outcomes for children and young people; continue to collate themes that inform service improvement and development.
- Increase capacity in the IRO Service

What difference have we made?

- Made significant inroads into IRO backlogs of LAC Review decisions
- Through use of QA Alert & Challenge Meetings, highlighted areas for concern as well as those of good practice across social work teams/management/services and influencing changes/improvements in practice e.g. seeing some improvements in performance as regards paperwork for LAC Reviews and contributing to the permanence and matching improvement work across the department.
- Identified areas for improvement as a result of IRO Training and development e.g. need for strengthened approach across the service in respect of oversight and governance of SGO pathways for children. Task & Finish Group established to address this.
- Influenced decision making in care proceedings to support good outcomes and make progress on stuck cases.

IRO Child Protection Service March 2017

Where were we?

- Building skills of IRO's in the developing practice using SoS approach in Child Protection conferences.
- Introduction of measures to reduce the number of repeat Child Protection Plans.
- The use of more outcome focused Child Protection Plans with clear actions, individuals, and timescales
- A SIU Team Manger as lead in the provision of consultancy, advice and practice in the area of children using sexual harmful behaviour (CuSHB). The SIU TM also took lead responsibility in chairing the multi-agency meetings.
- IRO's were offering challenge to practice, report quality, preparation of families and report timeliness but this was not consistently captured or escalated.

What have we done?

- Provided learning opportunities for the IRO's with tailored input from SOS registered trainers.
- Put in place checks around the activity of Core group and Children's Social care in effective management of the plan with the family and avoid premature ending of plan.
- Undertaken work within the IRO development days with the external trainer, alongside practice sessions as part of Team Meetings to further rehearse the skills needed to build family focused plans with clear outcomes
- Provided a consistent approach to the meetings where issues around children using sexual harmful behaviour (CuSHB) are discussed. Involvement with the re-shaping of the therapeutic service to be managed within CFS. Involvement in a small task & finish group that reviewed the use of the procedures.
- Introduction of a Quality Assurance (QA) Alert process that provides a consistent and visible record of issues being raised, or the identification of good quality work.

What else do we need to do?

- Continue with the further rehearsal of skills in the use of effective questions to elicit robust analysis from agency representatives.
- To work with all agencies in ensuring rigorous analysis of safety has been achieved that will ensure plans are ended in an informed way. This will be though work with the LSCB on effective partnership working.
- To further refine through practice workshops, observation of practice and shared learning the skills needed to assist members of Child Protection Conferences to build outcome based Child Protection plans with families.
- To monitor the use of the CuSHB procedures and assess the level of impact to embedded consistent practice.
- To continue to develop the consistent approach by IRO's to the use of the QA Alert. To continue to work with colleagues in ensuring issues are addressed in a timely and effective way.
- CP Conference Chairs to ensure robust approach when children have been on CP Plans 9 months+. Plans arising from CPCs to have clear & timely recommendations and actions to achieve permanence decisions with use of IRO QA Alert to assist in addressing drift and delay.

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What difference have we made?

- Consistent approach to the structure and content of Child Protection Conferences.
- Contributed to some early progress made in affecting a reduction in repeat Child Protection plans.
- There has been some observed improvements in the structure of family focused outcome based plans that are SMART
- CuSHB procedures have been revised, training programme for staff in place and strategic group set up to guide and oversee further developments.
- A more visible, consistent approach to QA's has begun, with a clearer auditable trail of progress and escalation.