LEICESTERSHIRE COUNTY COUNCIL

CHILDREN & FAMILY SERVICES

Safeguarding & Performance Unit

Independent Reviewing Officer (IRO) Service Annual Report 2017-2018

Leicestershire County Council

Content

Appendices

Leicestershire County Council

1. Executive Summary

1.1 2017-18 was a busy and challenging year for the Safeguarding and Improvement Unit with changes in staffing and increasing numbers of Looked after Children. The aims of the Safeguarding and Improvement Unit are to ensure that:

- The voice of children and young people is central and visible in decision making and planning.
- The right children are subject to a plan from the start
- The right level of support and intervention at each stage
- Improve timely outcomes for children and families
- Ensure all permanency options for Children in Care are prioritised
- To be in-line with or better than statistical neighbour and national data

Strengths – What is Working Well?

1.2 Average performance for the year in relation to timeliness of Looked After Children (LAC) Review of Arrangements remains high at 99.4% as is the case for timeliness of Review Child Protection Conferences (97.1%) and Initial Child Protection Conferences (95.1%). It is recognised that this is a slight drop from 2016-2017 but remains high and well in line with statistical and national data.

1.3 Participation performance remains a key area of development. The figure for 2017-18 is 92.3% which is a slight reduction from 95.3 % the previous year. Although this remains positive we are aspirational to improve this further. It is anticipated that a drive in 2018-19 to more consistently implement the Signs of Safety Methodology within LAC reviews will support effective participation.

1.4 There has been a significant improvement in the reduction of the use of multiple categories of risk in child protection planning. This was following previous concerns highlighted regarding an increasing use of multiple categories. A rigorous approach taken by IRO Conference Chairs over this reporting period has led to the number of multiple Categories of Harm for Children subject to Child Protection Plans continuing to reduce. In 2016-17 the figure was 109 and this has reduced to 41 in 2017-18.

1.5 The escalation process continues to be developed and is an established process which is recognised as celebrating areas of good practice as well as highlighted specific areas of concern and developing themes. There has been an increase this year of positive Quality Assurance Alerts in both LAC and CP. This highlights the increasing understanding of the impact of sharing good practice and the pivotal role of the IRO in supporting this.

1.6 To be successful, the IRO role must be valued by senior managers and operate within a supportive service culture and environment. The Safeguarding and Performance Review acknowledged the critical role of the IRO and highlighted the value associated with the role by supporting the re-

evaluation of the IRO role and also increasing the staffing establishment as part of growth monies

1.7 There continues to be really exciting development work as regards the departmental approach to working with children who display Harmful Sexual Behaviours (HSB). The development of processes within Mosaic provides an opportunity to make initial assessment of HSB more visible and also have a more consistent and monitored approach. The number of social workers trained in AIMS2, which is an assessment model for young people who have displayed sexually harmful behaviour, has risen significantly and how we utilise these skills moving forward will support a more robust and effective response to HSB within Leicestershire.

1.8 We have successfully recruited to posts within the service with experienced and suitably qualified practitioners.

Challenges – What are we worried about?

1.9 A department wide business support review took place during this period to improve the efficiency, effectiveness and consistency of the service. In the short term there was an impact on the stability of the Safeguarding Administration team and this in turn has impacted on the timeliness of the distribution of LAC review records, however the administrative team is now fully staffed and performs well. In addition there has been some pressure in 2017-18 regarding backlogs of records with IROs and the impact that this has had on meeting the statutory duty of distributions. IROs with backlog were given additional protected time to support them in achieving an acceptable position on completing records.

1.10 There continues to be concern in relation to the timeliness of reports to LAC reviews and Initial Child Protection Conference (ICPC)/Review Child Protection Conference (RCPC) being shared with families and IROs. However within the reporting period an improvement has been highlighted. This is a key area of performance being driven within Children and Family Services and whilst this is positive it remains a work in progress to ensure that we continue to improve and maintain improvement within this area.

1.11 IRO challenge on behalf of children is more robust. However whilst we have made significant progress in evidencing the tracking and footprint of IROs within LAC cases, there continues to be work needed in this being replicated with CP cases and this having a visible and timely impact.

1.12 The analysis of escalation and the responses to Quality Assurance Alerts needs further work. IROs have not always escalated concerns when a response is not satisfactory/or responded to, setting realistic timescales that guard against delay. We need to ensure that the process is robustly implemented beyond the first QA and themes for positive and negative QAs are more effectively analysed and utilised in development work throughout CFS.

1.13 Repeat CP plans continue to remain higher than in comparison to statistical neighbours, although improvement within this area is recognised. The work by IROs in ensuring robust assessments are utilised and SMART (Specific, Measurable, Achievable, Realistic, Timely) step down plans are in place for the ending of CP plans. The IROs complete an analysis tool for all incoming repeat plans and this needs to continue to be driven forward and is an area for improvement.

1.14 HSB policy needs to be more widely known and implemented throughout Children and Family Services. We need to ensure that we are able to track and assess cases where an HSB meeting has been undertaken but also the cases that did not meet the threshold, to ensure children and young people are receiving the right support at the right time.

Areas for Improvement – What needs to happen

1.15 To further develop the practice of IROs a continuing programme of input from skilled external trainers is in place through 2018/19. The impetus to sharpen delivery through best questions and family based plans with effective family owned safety plans.

1.16 IRO Team Managers will have a robust oversight of cases to ensure that there are no backlogs. Workloads will be discussed routinely within supervision and there is a clear expectation of performance consistently applied to all IROs.

1.17 IROs to continue to support and drive forward the improvements in the timeliness of social work reports to LAC reviews and CP conferences in order that the achieved improvements can be increased and sustained.

1.18 IROs to consistently use the escalation process to challenge all areas of concern to improve outcomes for children and also to be used to effectively highlight good practice. There needs to be more effective management oversight of the QA process with QAs being discussed in supervision and feeding into the pre-challenge tracker.

1.19 IROs to continue to produce an analysis to Safeguarding and Improvement Unit (SIU) Team Managers in cases of repeat CP plans. This analysis, in addition to the quarterly audit, to be used to develop practice and inform learning.

1.20 HSB development (task and finish group) 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.

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2. Introduction

2.1 The Annual Report for the Independent Reviewing Officer (IRO) sets out the current performance for the service in 2017-2018 and identifies our priorities for the forthcoming year. The service provision of the Safeguarding and Improvement Unit is driven by our vision and mission and is underpinned by the shared values of the Children and Family Services.

OUR VISION Leicestershire is the best place for all children, young people and their families

This means that we will describe the outcomes we want to achieve for children, young people and their families and identify measures that can tell us how well we are achieving them in comparison with other English local authorities. We will aim to be the best performing local authority in the country against these measures, and where we are not yet there we will set stretching targets for annual improvement.

OUR MISSION

Children and young people in Leicestershire are safe, and living in families where they can achieve their potential and have their health, wellbeing and life chances improved within thriving communities.

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

2.3 IROs 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. All IROs have a combination of Child Protection cases and Looked After Children.

2.4 IROs have a critical role in the quality assurance framework within Children and Family Services and they have key duties that scrutinise and support the quality, safety and effectiveness of safeguarding practice and policy, Care Planning and Permanence. IROs are central to identifying and sharing good

practice and checking the quality of provision across the areas of Child Protection and Looked After Children.

2.5 IROs 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 IROs 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. The role of the IRO is to provide robust oversight and independent challenge where decisions are not deemed to be in a child's best interest. An effective IRO service will drive forward improved outcomes for children and young people and will ensure that his/her current wishes and feelings are given full consideration. To be successful, the role must be valued by senior managers and operate within a supportive service culture and environment. It is not the responsibility of the IRO to manage the case, supervise the social worker or devise the care plan.

2.6 In Leicestershire as the IROs also undertake the Conference Chair role, the expectation is that the IRO will apply the same quality assurance approach as regards 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.

2.7 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 2017 to March 2018. 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.

2.8 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 for example LAC Reviews, and all other references will refer to Children in Care (CiC).

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3. 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 handbook 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 (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. IRO Service

4.1 The position of the IRO Service being within Children's Social Care is viewed by the service as beneficial overall. It enables IROs to have a good

understanding of the local authority and the context in which they operate such as areas of demand and pressure including impact of recruitment and retention. IROs have direct access to case records and therefore full information relating to a child's case and are able 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 In 2017-18 the Safeguarding and Improvement Unit has been part of a wider review of the Safeguarding and Performance Service. The purpose of the review was to take a whole systems and department wide approach to Safeguarding, Quality Assurance and Performance Improvement and to work collaboratively across different service areas. The review proposals took account of the issues within the Safeguarding and Improvement Unit relating to recruitment and capacity. The issue of sufficiency within the IRO Service has been identified as a concern within previous annual reports highlighting the challenges for the service to consistently deliver high standards of practice and provide robust oversight and challenge. As a result the action plan included an additional 1.95 (FTE) IRO posts *(This includes 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).* The IRO posts were also re-evaluated from a grade 12 post to a grade 13 and the Team Manager Post was reviewed, revised and re-evaluated from grade 13 to grade 14. The action plan was launched on 8th August 2018 and therefore the impact of the changes will be reflected in the annual report 2018-2019. (See appendix D for the structure chart).

4.3 Towards the end of 2017-18 the Safeguarding and Improvement Unit has experienced significant changes in staffing with a new Service Manager being appointed in January 2018 and both Team Managers who had been established members of the team leaving in March and April. Two IROs successfully interviewed and were appointed to act up into the role of Team Manager until the permanent positions were advertised and appointed to. In addition to these staff changes the Safeguarding administration team has also been part of business support review which had a significant impact on the continuity and stability of staffing that had previously been experienced. The Safeguarding administration team is imperative to ensuring that the IRO service effectively meets its statutory duty and changes in staffing has added challenges and difficulties.

4.4 Over 2017-18, 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. At the end of March 2018, the service had 13 FTE represented by 14 individual IROs. 11 members of staff are permanent employees and the other 3 are agency IROs currently contracted to the end of October when the permanent staff will be in post.

4.5 Caseloads for IROs (FTE) over 2017-18 have continued to be at the higher end of the recommended guidelines as per the IRO Handbook (50-70), with the average being 80.5 (FTE). It has been recognised that the IRO handbook guidelines refer to caseloads for Looked After Children. IROs hold both LAC and CP caseloads. In March 2018 a weighting process was implemented to recognise the workload implications of the two different roles and within this process each LAC case is identified as 1.5 cases and CP cases as 1. This enables better analysis and oversight of caseloads by Team managers to ensure equity and consistency of practice across the team. Even with the agreed increase in the post establishment of the IROs, the increasing numbers of LAC will continue to have an impact on capacity and this will need to be assessed and analysed moving forward.

4.6 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 of 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*
- *Modern Slavery.*
- *Unaccompanied Asylum Seeking Children (UASC)*

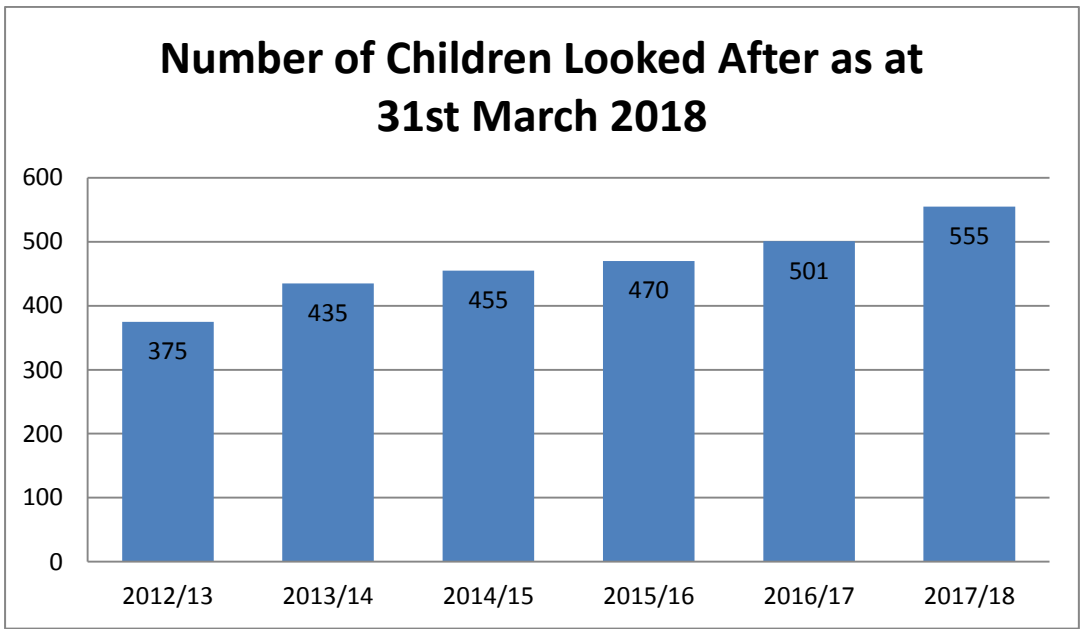
4.7 All IROs have had bespoke training in Signs of Safety, relevant to their role – this has continued to include 3 in-depth development days provided throughout the year and are provided as part of the England Innovations Project (EIP2) that Leicestershire County Council is part of. These additional training opportunities are continuing into 2018-19 as the department continues on its journey to embed the Signs of Safety methodology in its culture and practice. There is the expectation that all IROs will attend the Practice Lead development training opportunities in addition to the bespoke provision. IROs are at the forefront of developing and deepening Signs of Safety practice with the implementation of their quality assurance role and therefore it is critical that their Signs of Safety knowledge and skills remain comprehensive.

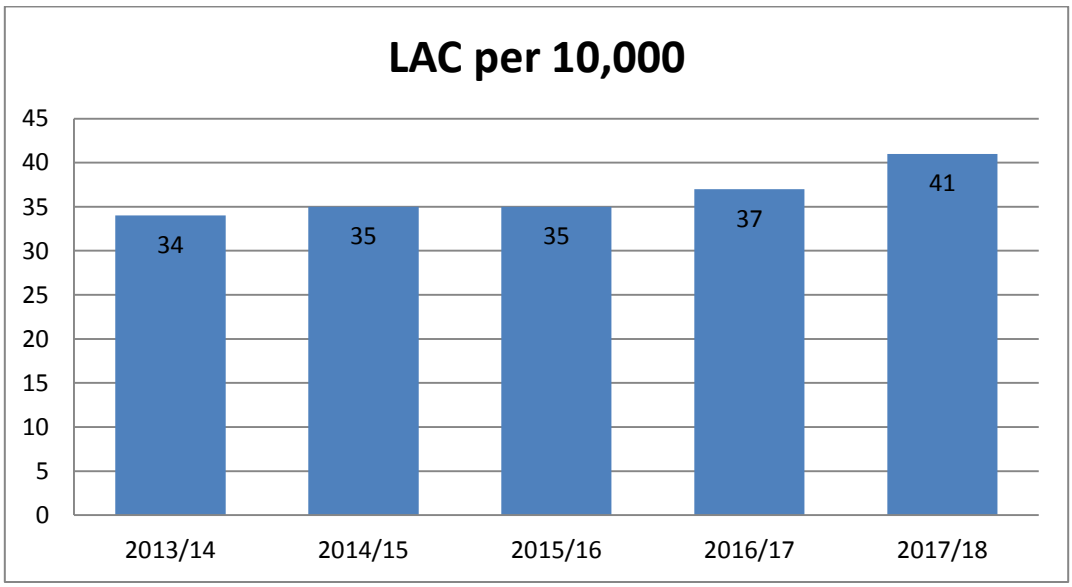
4.8 The expectations on IROs are significant and the IRO Service in Leicestershire remains committed to delivering a high quality service. This commitment is supported by the implementation of a service specific Learning Audit Framework (2018-2019) which highlights areas of need and provides a

framework of observation, peer audit and audit analysis to inform learning and drive forward best practice (Appendix E).

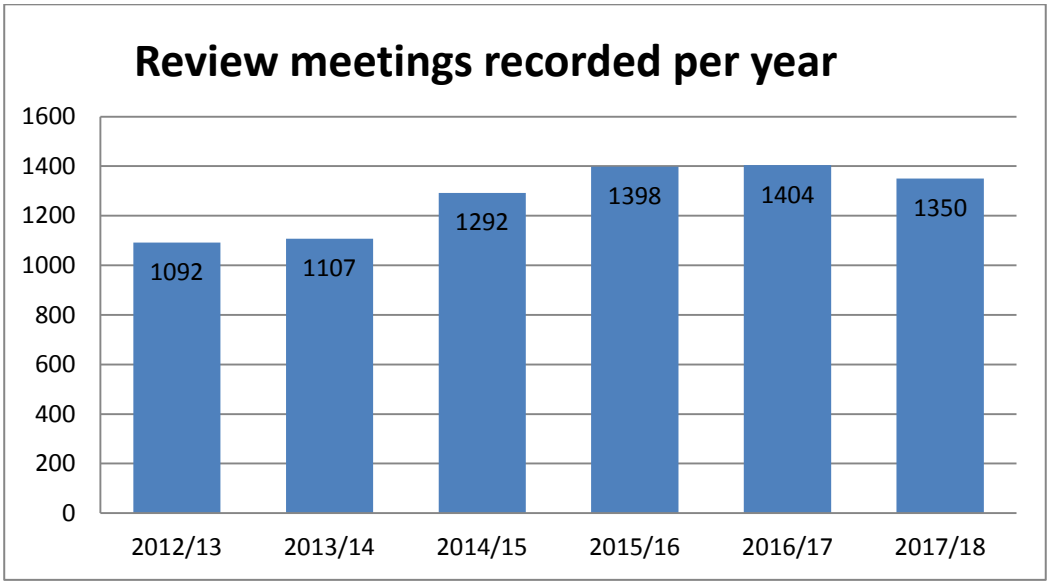
5. Independent Reviewing Officer Children in Care Services

5.1 As can be seen from the table below, the children in care population in Leicestershire has increased further over 2017-18, in keeping with a steady year on year increase over the last 6 years. Whilst recognising that the number of looked after children in Leicestershire continues to be increasing and drawing closer to the statistical neighbours average, it remains lower at present. Leicestershire has 41 per 10,000 looked after children, whereas the statistical neighbour average is 50.6 per 10,000 children.

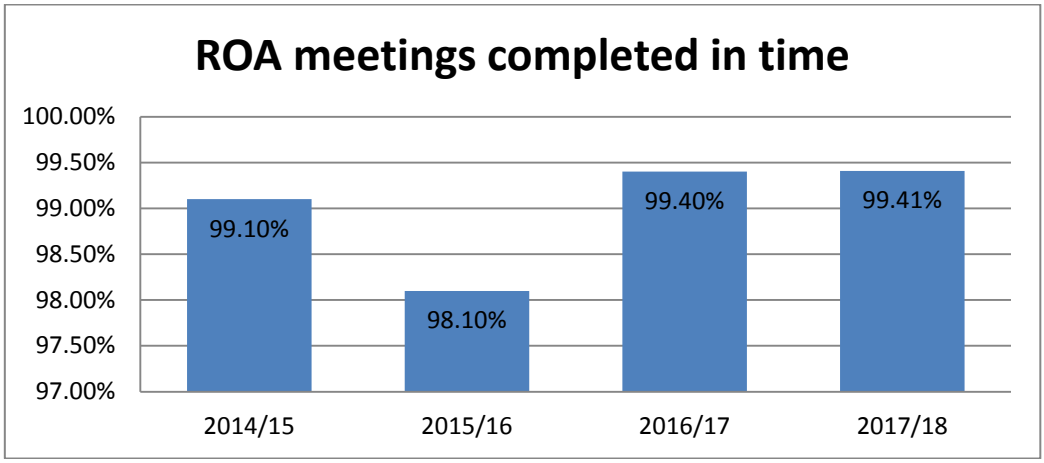




5.2 The activity generated from this is reflected in the number of review meetings held for children between 1st April 2017 and the end of March 2018 which totalled 1350 (please note this is meetings held, not individual children's meetings, thus a sibling group of 3 whose meeting was held together would count as one meeting). The total number of meetings held for children individually was 1488. 1350 is slightly lower than the previous year. One would assume that given the number of looked after children has risen, this would result in additional meetings generated. This is absolutely the case, however in some circumstances, additional Review of Arrangement meetings are convened by IROs and this could be due to significant changes to the care plan resulting in the need for an additional review, concerns regarding drift or delay, the need for additional reviews in order for the IRO to endorse a final care plan in line with Care Proceeding timescales. Therefore, in the previous year, there may have been an increase in additional reviews resulting in the number of meetings held being higher than this current year. In some respects this could demonstrate improvements within care planning, timescales being met for the IRO to endorse the care plans, thus resulting in the IRO not needing to convene additional meetings to review and have oversight of the care planning.



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



5.4 There were just 8 reviews that did not take place in time over the year. In five of these Review of Arrangements, the Looked After Children business support team were not notified within timescales of the child becoming accommodated and thus the 28 day ROA had not been requested. On one occasion the IROs car broke down on the way to the review and the Social Worker was off sick so a Part One, with subsequent Part Two was not possible. A Social Worker did not respond to LAC admin on one occasion where they were trying to arrange for a two part ROA so this went out of timescale. The final ROA was an out of county ROA, and due to the severe weather conditions in February, it was not possible for this meeting to go ahead and it was agreed with the Service Manager that doing the ROA in two parts, in this particular case, was not possible. Within the Safeguarding and Improvement Unit, we are very committed to ensuring Review of Arrangements meetings are held within timescale. The business support team works hard in communicating with Social Workers and managing IRO diaries to the best of its ability to ensure timescales are met, thus such high figures being achieved and maintained.

Participation

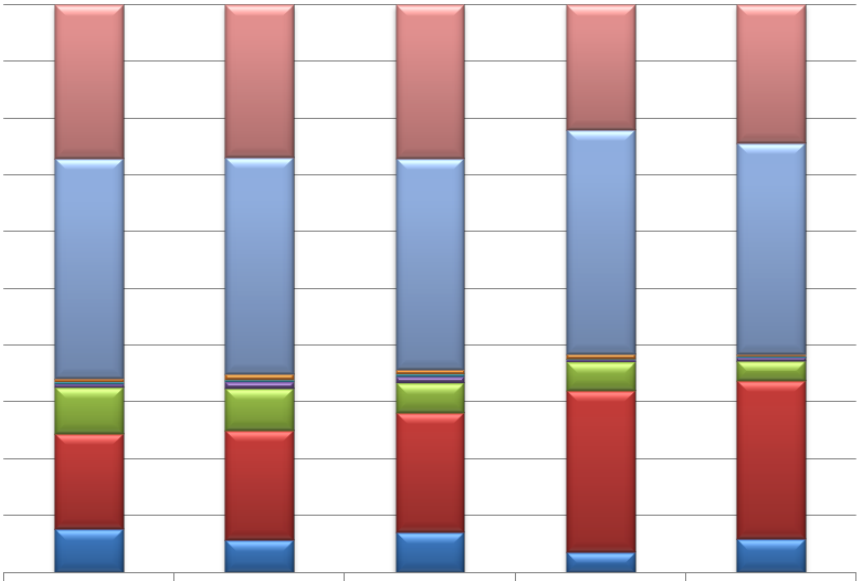
5.5 The child and young person's voice, their views and wishes are essential to the care planning. IROs continue to strive towards obtaining this and ensuring children and young people actively participate in the review process. Not all children will want to attend a meeting; therefore IROs are creative in the ways in which they can support the child in participating, working closely alongside Social Workers and Carers. The IRO service is looking at ways in which this practice can be further developed, including being more creative with Signs of Safety within the review process and promoting active participation.

5.6 Participation is defined across 7 different indicators:

PN0 Represents children under the age of 4
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.

5.7 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.



	2014	2015	2016	2017	2018
PN0	319	351	381	309	363
PN1	459	495	522	550	554
PN2	6	14	10	13	4
PN3	4	4	7	3	2
PN4	7	16	15	4	11
PN5	97	97	74	70	52
PN6	199	250	295	399	415
PN7	90	75	100	50	87

5.8 Overall 92.3% of children and young people participated in their ROA meeting process in 2017-18 which is a slight decrease from 2016-17, which was 95.3%. There had previously been a steady increase over the last 4 years, with 90.2% in 2015-16 and 92.5% in 2014-15. The percentage is determined by all codes PN1 to PN6, which are all reviews where the children can participate, thus excluding PN0 (children aged under 4 at the time of the review). Following this principle, there were 1125 reviews where the child could participate in 2018, of those there were 1038 which had a participation code PN1 to PN6, and this gives a percentage of 92.3%.

5.9 The IRO service has worked hard in developing ROA meetings to make these children focused and support the young people in participating in their meetings. It should be noted from PN1 - Children who attend their reviews and speak for themselves, there was an increase by 4 young people from 2017 and this is the highest number in the last 5 years. These figures continue to reflect the commitment and hard work completed by the team to ensure young people attend and actively engage in their meetings, however it

is evident that involving children in their reviews needs to continue to be promoted within the service and further development work will continue to ensure that participation is key on the IRO agenda.

5.10 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. IROs are being creative in ways in which they can obtain the views and wishes of young people who do not attend their reviews, outside of visiting; this includes using email, texts, phone calls and skype. Communication methods many of our young people are familiar with. For children where communication can be more difficult, the IROs continue to work closely with their Social Workers, Carers and other key professionals to be guided on different tools and approaches which can be used to obtain their views and wishes and ensure their participation.

Review of Arrangements (ROA) Records Production and Distribution

5.11 The ROA records continue to reflect the Signs of Safety methodology. The IRO service has recently spent a team day looking at ways in which we can further develop Signs of Safety into the facilitating of ROAs and also the ROA records. The service continues to be committed to the consistent use of the Signs of Safety model as part of The Road to Excellence Continuous Improvement Plan and is something we continue to thrive to develop further, with the support from our Signs of Safety Consultant. The team meets with the consultant three times a year to develop our practice and improve service delivery.

5.12 The IRO Service has been working hard to reduce the backlogs of review records, whilst managing the continuing challenges regarding capacity and the increase in children in care and child protection numbers; it has meant we have not been able to eradicate the backlog completely. An expectation of how many records completed on protected admin days has enabled progress to be made and consistency across the service. IROs who had particularly large backlogs have been supported to have additional admin time and plans have been devised with timescales for these being up to date. The management team is working closely to review caseloads and ensure workers have protected admin, thus reducing the risk of backlogs rebuilding. With IROs having protected admin in their dairies weekly and capacity issues being actively addressed, we have every confidence this will quickly improve and the measures put in place will ensure that records are completed within timescale and backlog figures will reduce.

5.13 The department wide business support review understandably created some instability in the short term but the business support managers worked closely with the Senior Managers to increase staffing capacity by recruiting temporary staff to help ensure the core business was completed. Whilst the distribution of records was affected in the short term this was quickly resolved. Records recorded as being within timescale are those written by the IRO and distributed within 20 working days.

End March 2017	297 out of timescale
End March 2018	495 out of timescale

5.14 As evidenced above, there was an increase in nearly 200 records being sent out of timescale in the last year. There are a number of factors which can result in the ROA record not being distributed within timescale. This can be due to a delay with the IRO completing the record out of timescale or the IRO completing in timescale and admin being unable to distribute within the required time, or a mixture of both. The IRO service has developed plans to enable IROs to have the required admin time to ensure records are completed within the expected timescale. We are confident that now the new admin workers are in post and the vacancies filled, the distribution of records will be completed in accordance with required timescales also. Therefore, we anticipate this area to significantly improve over the forthcoming months.

5.15 The IRO Service continues to have the completion of ROA records and distribution high on the agenda and there is robust management oversight in place to work to address any areas of concern. Within supervisions, review records and child protection records are discussed with any workload issues being addressed with proactive work plans put in place for individual workers. In addition this is routinely discussed within team meetings, along with exploring ways of more smarter and efficient working. Managers within the team are working together to ensure workloads are carefully managed, allowing admin time for IROs as well as meeting the demands of the service and the required timescales. We are confident this is an area that will significantly improve within the next couple of months.

Social Work Reports for Review of Arrangement (ROA) meetings

5.16 Social work teams continue to strive towards improving the timeliness and quality of their reports and care plans that are provided to ROA meetings. IROs will use the Quality Assurance process to address any issues in respect to timeliness or quality. Social Workers and Team Managers have responded well to this process and this has seen improvements being made. IROs actively promote the importance of the Social Worker's report, detailing their up to date assessment and in addition the care plans. Both documents are essential to the IRO considering what progress is being made for the children and young people and reviewing this within the meeting. They ensure the plans are focused on the needs of the child or young person and are covering key areas including permanence, health, education, contact and their emotional and social wellbeing. They are a tool to ensure that the decisions being made by Local Authorities are in the best interest of the child and supporting them in reaching their full potential.

5.17 The Service Manager has been part of a working group to look at revising the current templates for the ROA meetings. This is with the view to make them more child friendly, including Signs of Safety, and streamline them similar to the reports used for conference. There continues to be some confusion amongst workers as to which template they should be using for the reports, resulting in inconsistency across the different teams and areas. Once the new

template is launched, this will also help ensure consistency and help improve the quality of reports being provided. IROs will continue to play a key role in the quality assurance of the reports and providing both constructive and positive feedback.

Care or Pathway Plan paperwork available to the IRO 24 hours prior to the ROA

5.18 At the end of 2017-18 on average, 47.9% of Care or Pathway Plans had been available to the IRO 24 hours prior to the ROA meeting. The data also highlighted a reporting issue from April – August 2017 with a large number of 'null'. This was an issue with the monitoring form which is now a mandatory field ensuring its completion. 47.9% is a decrease from 2016-17, where the average was 56.3%. Whilst this average is disappointing, the IRO service recognised during the first quarter that this was a concern and practice needed to be addressed as a matter of urgency to address this issue. As a result IROs were directed to send Quality Assurance alerts if reports were not received within timescales and from August 2017, we saw a dramatic increase, raising to 56.3% and the following months were all over 65%, with performance reaching a high of 84.1% in March 2018. This evidence suggests that overall performance has improved significantly with Social Workers working hard to ensure timescales for reports are met. It is positive to observe the increase in the statistics which IROs are encouraged to remain focused on, ensuring they address any performance issues via the Quality Assurance process in respect to timescales, thus ensuring this performance continues to be sustained.

Updated Social Work Assessment Report available to the IRO 24 hours prior to the ROA:

5.19 At the end of 2017-18 on average, 51.6% of updated Social Work assessment reports had been available to the IRO 24 hours prior to the ROA meeting. This figure is in line with the percentage of updated Care or Pathway Plans received within timescales. Similar to the above statistics, once the IRO service raised this concern and were committed to improving this performance via the Quality Assurance alert process, an increase in reports being received in timescale was observed from August 2017, reaching 70.9%. It is positive to note that since August 2017, the percentage of reports received has always been over 70% and at the end of March 2018 was 84.1%. The IRO service will continue to monitor performance in this area and any concerns will be addressed via the Quality Assurance processes.

Permanence

5.20 Securing permanence for children in a timely manner continues to be high on the agenda for IROs and something which is regularly reviewed during ROA meetings. IROs will arrange additional ROA meetings to be convened if there are concerns regarding drift and delay in respect of permanence and care planning, as well as using the Quality Assurance alert and escalation process. CFS has developed the Permanence Panel which sits fortnightly and the

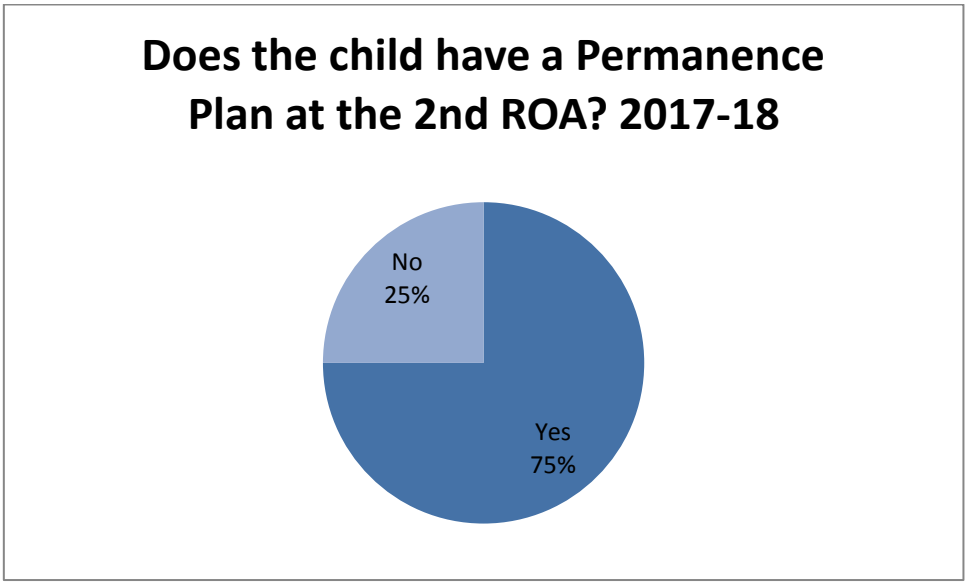
Service Manager attends this. As a result of the Permanence Panel being implemented there have been significant developments in respect of children's permanence being secured and management having rigorous oversight of the care planning for children. This has enabled decisions to be made in a timely way, thus reducing drift and delay for children.

5.21 The Permanence Panel not only reviews children subject to Care Proceedings but also makes matching decisions for children requiring long term placements. The Local Authority is committed to improving the matching processes for children who require long term care and increasing the percentage of children who are in the same placement for two years or more. IROs share their views as part of the reports presented to the panel and make recommendations regarding matches and care plans.

5.22 In between ROA meetings, IROs will also routinely track cases and this is recorded on the child's file on Mosaic as IRO case tracking. The IRO footprint has developed significantly over the last 12 – 18 months, with IROs ensuring they have oversight during review periods and addressing any concerns regarding drift and delay. This has enabled the ROA meetings to be more focused on reviewing the care plans and needs of the child, as opposed to actual care planning meetings. In addition to this, it further evidences our commitment to The Road to Excellence Continuous Improvement Plan by demonstrating strong and effective management oversight and rigorous decision making.

5.23 IROs also share their views for other panels and decision making forums, including the Residential Review Panel, Case Decision Making meetings, Position of Trust meetings and to the Agency Decision Maker. These views are recorded on Mosaic as the view of the IRO and again further evidences the oversight and footprint of the IRO within the care planning process.

5.24 Upon completion of ROA meetings, IROs complete a monitoring form advising of the outcome of the meeting in respect of the Care Plan for the child. A new monitoring form was devised to include the permanence plan for the child. For the period of 1 April 2017 to 31 March 2018 there were 1010 ROAs held that had the new monitoring form completed, with the permanence question answered and of those, 250 had NO for the question 'Does the child have Permanence Plan'; 750 had Yes. It is key to note that for some children at the 28 day ROA they may not have a permanence plan due to just coming into care, proceedings having just been initiated etc. Therefore, 75% of children having had Permanence Plans in place evidences the drive within the department to ensure permanence is secured for children within a timely manner, with little drift and delay and endorsed by the IRO during the ROA meeting.

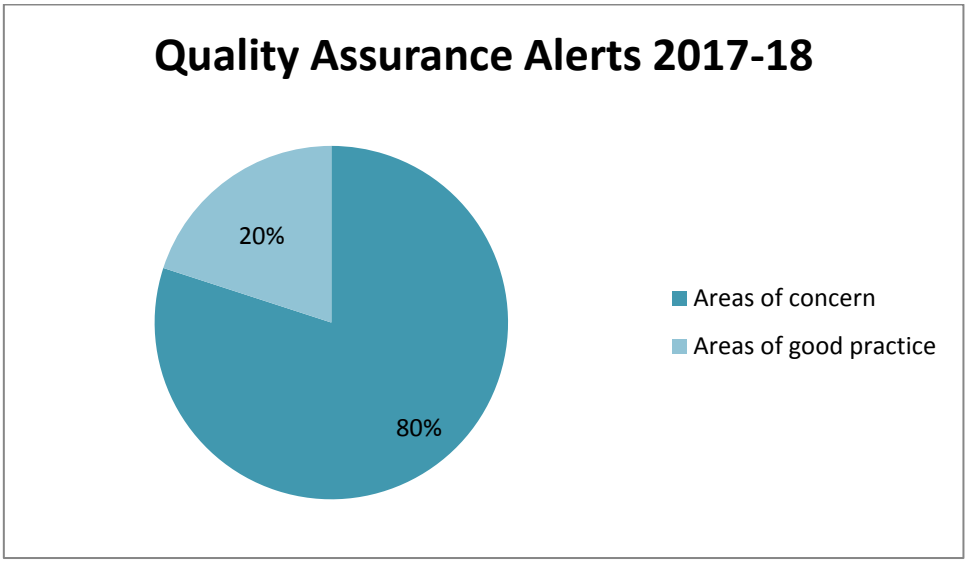


5.25 The local authority has been committed to achieving permanence for children in a timely way who are unable to be kept safe within their families. This is a key theme within the Continuous Improvement Plan – The Road to Excellence and it is positive to see that the permanence indicators above evidence the improvement and outcomes for children in respect of permanence being achieved in a timely manner for children and young people. The IRO service continues to quality assure the proposed plans as well as challenging drift and delay, thus contributing to ensuring the time in which children are looked after before a permanence decision is achieved is continuing to reduce.

IRO Challenge & Escalation

5.26 Since September 2016, the Quality Assurance Alerts have been used by the IRO service effectively to identify areas of good practice as well as areas of concern, including quality and timeliness of reports, drift or delay in care planning, concerns regarding statutory duties not being met and areas of practice which need developing. As a service, we have routinely reviewed the Quality Assurance Alerts to help identify any key themes or areas which need to be addressed; this is then shared within the Senior Management Group.

5.27 From 31 March 2017 – 1 April 2018, there were 115 Quality Assurance alerts completed in respect of children in care. 23 were for good practice and 92 were regarding cases where an element of the case had been highlighted as requiring further work. This is an increase from September 2016 – 31 March 2017, where there were 77 Quality Assurance alerts completed- 16 for good practice and 61 for areas of further work.



5.28 The key areas of good practice identified were in relation to good quality reports, assessments and plans. IROs recognise the importance of acknowledging good practice and ensuring this is formally recorded via the Quality Assurance process. Feedback from Social Workers and Teams is that the receipt of positive Quality Assurance alerts is very much welcomed and helps build on workers confidence, self-esteem, enabling them to be proud of their hard work and commitment to our children and families. It should be recognised that this is an area where we need to continue to develop, and we need to be ensuring good practice is regularly acknowledged, as this contributes greatly to staff feeling valued and positive morale within individuals and teams.

5.29 The key areas of concern have been in relation to drift and delay within Care Planning. As a result of sending the Quality Assurance alert, the IRO will be requesting an urgent explanation as to the reasons for the drift / delay, followed by identifying clear expectations of work to be completed to address this. They then continue to have oversight of the progress and will use the escalation process when needed.

5.30 The themes from the Quality Assurance Alerts are fed into performance and practice forums across Children's Social Care and connect into the department's Quality Assurance Improvement Framework. The feedback from the identified themes is welcomed by Senior Managers to enable us to continue to develop practice and improve the outcomes for our looked after children.

5.31 IROs ensure that the escalation process regarding the Quality Assurance Alerts is implemented within the timeframes identified. Team Managers are required to respond within 5 days and if no response is obtained or the concerns continue to be present, it is escalated to the relevant Service Manager and similarly, if no response is received within 5 working days the matter is raised with the relevant Head of Service. Following the escalation process being completed, if the concerns remain, discussion can take place with the Assistant Director at the Challenge Meetings. IROs work persistently

to try to get the matter resolved in a timely manner with the management group and are overall effective in doing so. Thus few cases require discussion with the Assistant Director.

5.32 IRO case tracking, auditing and Quality Assurance processes enable the IRO to have rigorous oversight of care planning for children as well as ensuring the consistent application of thresholds, improved quality of assessment and care planning and strong management oversight at all stages of a child's journey. This also promotes and implements a learning culture for workers, recognising and supporting areas of required improvement and acknowledging good practice.

5.33 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 have been two occasions over the reporting period where a referral for independent legal advice was made, due to the IRO not being in agreement with the proposed local authority Care Plans. Both cases were subject to Care Proceedings. On both occasions, the matter was resolved with an agreement being reached, and the IROs did not have to attend Court.

5.34 We are seeing an increase in the number of IROs who are being requested to complete statements to Court, giving their view on proceedings, proposed Care Plans and contact arrangements. This is in addition to the legal view which is routinely completed by IROs. There have been 3 occasions (3 families – 8 children in total) during 2017-18 where IROs have had to write statements to Court. On all occasions this has resulted in several statements being filed. The IROs are able to seek independent legal advice to have their statements read before filing if needed. On one occasion this happened, the other two occasions the Team Manager and Service Manager read the statements and supported the IRO. On all 3 occasions the IRO and local authority were able to agree on the final Care Plans, and the IRO did not have to give evidence as part of the proceedings.

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

5.35 The management group for the Safeguarding Unit meet each month for a Pre-Challenge Tracking Meeting, to discuss cases and themes of concern. It is then considered whether these cases / matters need to be taken to the Challenge Meeting with the Assistant Director, or if further actions need to be taken in the first instance. A tracking spreadsheet is kept with a log of these discussions and the cases / themes are followed up with the allocated IRO during Supervision or during Team Meetings if necessary.

5.36 Following the Pre-Challenge Tracking Meeting, the managers from the Safeguarding Unit meet with the ADM and Assistant Director on a monthly basis to discuss identified areas of concern. Cases that are discussed in this forum are cases which have followed the full escalation process. Given the

quality assurance role of the ADM, in particular in respect of permanence, this working together forum is key to identify themes and areas of practice which need further development. It is important to note that there are occasions where the meeting is not required as at that time there are no cases / themes which require the oversight of the Assistant Director.

5.37 As an outcome of case discussions held at the Challenge Meeting, we have been able to resolve a number of cases in a timely manner, achieving positive outcomes for children. In addition this has also enabled learning opportunities for the practitioners involved, thus contributing to further developing and improving practice and care planning.

5.38 As regards the themes fed into, as well as arising from, the Challenge Meetings, again, there are a number of development projects 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.

Cafcass

5.39 The IRO service continues to maintain a good working relationship with CAFCASS Children's Guardians, at both IRO and management level. IROs routinely liaise with Children's Guardians during Care Proceedings and ensure their views on the care plans are represented. In addition to the liaison with the Guardian, the IRO also completes an IRO legal view on the proposed final Care Plan, which is emailed to the local authority's legal representative and included within the final Court bundle.

5.40 There has been an increase during the last year where IROs have also been asked to provide statements to Court highlighting their position regarding the care planning and have been asked to be prepared to give evidence in Court if required. This further evidences the importance and degree in which an IROs view is considered within the Care Proceedings for children. The IROs who have been required to do this have done so competently, focusing on providing evidence based statements for the best interest of the children.

5.41 We have also seen an increase in the number of Children's Guardians who attend Child Protection Conferences and ROA meetings, thus further strengthening the working together and communication between both services.

5.42 The admin support systems continue to improve the communication, ensuring IROs receive the 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 ROA meetings for children and young people and ensure they always have a copy of the ROA record if they were unable to attend and always have the dates of upcoming ROA meetings.

Family Justice Board

5.43 The Service Manager attends the Family Justice Board meetings. This enables the IRO Service to have a direct connection into Family Justice Board and the Performance Sub Group of the Board. This assists with the IRO service being kept up to date with any issues arising from the Public Law work that in turn influences IRO practice. It also enables IROs to continue to be up to date with changes to legislation, policies and procedures, enhancing their oversight of the practice and performance of the local authority in respect to children who are subject to care proceedings. This in turns helps ensure timely care planning and better outcomes for the children. The Service Manager ensures the IRO service is updated of key information via Team Meetings, emails and supervision.

Regional IRO Forums

5.44 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 2017-18 covering areas on CAFCASS, CAFCASS plus and Placement with Parents, dilemmas in Adoption and the hidden responsibilities of an IRO. Unfortunately due to the severe weather conditions the scheduled meeting for February was cancelled.

5.45 The IROs are all supported to attend these meetings, with no other commitments being put in their dairies. These meetings are a fantastic opportunity for IROs to increase their knowledge and expertise, whilst learning from their colleagues. It enables them to connect with the other regional managers and IRO groups, ensuring they are keeping up to date with relevant changes to legislation, policies or procedures as well as obtaining ideas for developing our own service. Thus, improving the practice delivery in their role and ensuring the service children and young people receive.

6. Independent Reviewing Officer: Child Protection Chair

Child Protection Conference Activity

6.1 The number of Initial and Review Child Protection Conferences chaired over 2017/18 was 932, which equates to 2,091 Children. Of these 79 children (which is 13.2% of children that had an Initial Child Protection Conference) were not made subject to a Child Protection Plan. The small number of children not being made subject to a plan at ICPC highlights that we are getting the assessments right and that thresholds are being implemented more consistently. We are currently in line with our statistical neighbours data of 13.6%

Numbers of Child Protection Plans

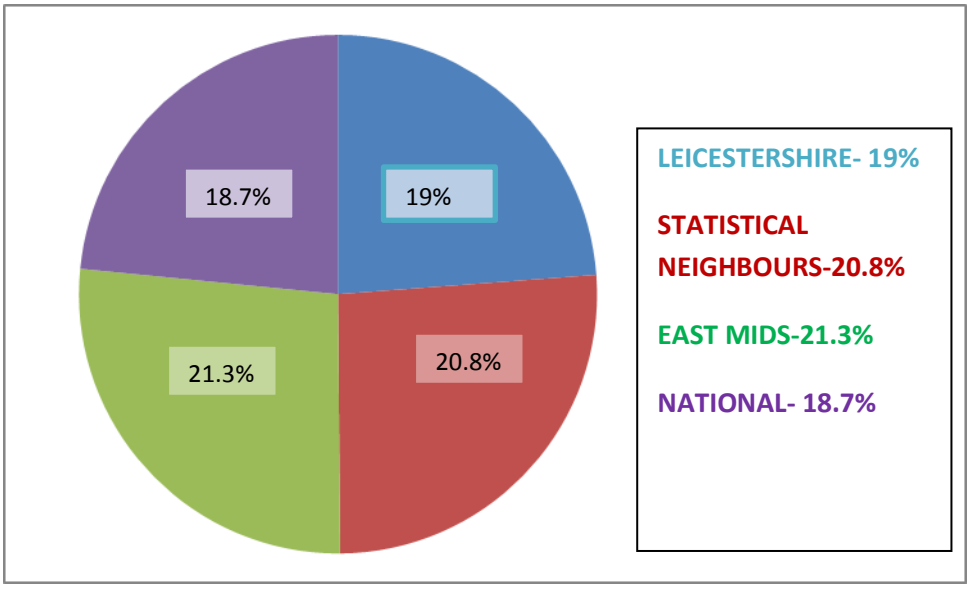
6.2 Numbers of children subject to child protection plans measured at year end (31st March 2018) has decreased from the previous year:

2016-17	434
2017-18	394

Repeat Child Protection Plans

6.3 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 reduced; this was following a thematic and senior management audit on repeat planning. IROs contributed to this audit work by undertaking analysis of each case where the children had previously been subject to a Child Protection Plan, identifying themes and learning, to better inform practice. This has continued to be common practice for the IROs. Repeat planning figures got down to approximately 18%, although it has been identified that this audit is needed to be completed again and more regularly to ensure our repeat planning figures do not creep back up to 30%, as it did in 2016. The figures for the reporting year 2017/18 show that the repeat planning figures were at 19%.

Repeat planning figures for 2017/18	**%**
Leicestershire	19%
Statistical neighbours	20.8%
East Midlands	21.3%
National	18.7



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

6.5 Children in Need practice guidance has been developed and a number of measures put into place to ensure children receive the right service at the right time, reducing the need for repeat Child Protection Planning. Therefore when a Child Protection Plan ends and it is agreed that there should be a step down to a Child in Need plan the role of the Conference Chair is significant, and this robust practice will need to continue and will require more direct focus in this area by the Conference chairs which will encompass:

- All elements of the Child Protection Plan are effectively reviewed and there is evidence of progress being made and has been sustained and there is clear evidence that the Safety goals have been achieved.
- There is evidence of management oversight as regards assessments and recommendations to end plan
- Conference Chairs facilitate the discussion regarding Child in Need plans when they are an outcome of conference to ensure plans are robust, generated by the family, their network and professionals to continue to engage with the family.
- The Conference Chair will ensure that dates for meetings are discussed, particularly the initial Child in Need meeting which should be within 10 working days of the step down from Child Protection planning also establishing rates of reviewing the Child in Need Plan and minimum length of time that the case will be open.
- The Conference Chair will make recommendations regarding significant elements of the Child in Need Plan that they feel should be part of the Child in Need Plan.
- There is a great emphasis on all plans being SMART (Specific, Measurable, Achievable, Realistic, Timely)

Plans Ending

6.6 Over 2017/18 the performance data showed 3.5% of Child Protection Plans ending at the first review/less than 3 months on a plan. Some analysis was undertaken in respect of this finding and it was identified that it was a continued theme from the previous year which established that in the majority of cases there was a safe rationale for ending the Child Protection Plan, largely due to the child/ren becoming subject to legal proceedings and in local authority care, therefore no longer needing a child protection plan as their care will be overseen by an IRO and there is no need for dual planning.

Length of Plans

6.7 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 how robust the approach is in bringing about lasting change/permanence for children and young people.

6.8 Whereas Ofsted were complimentary of child protection conference chairs in their review of child protection plans for children and young people, they also

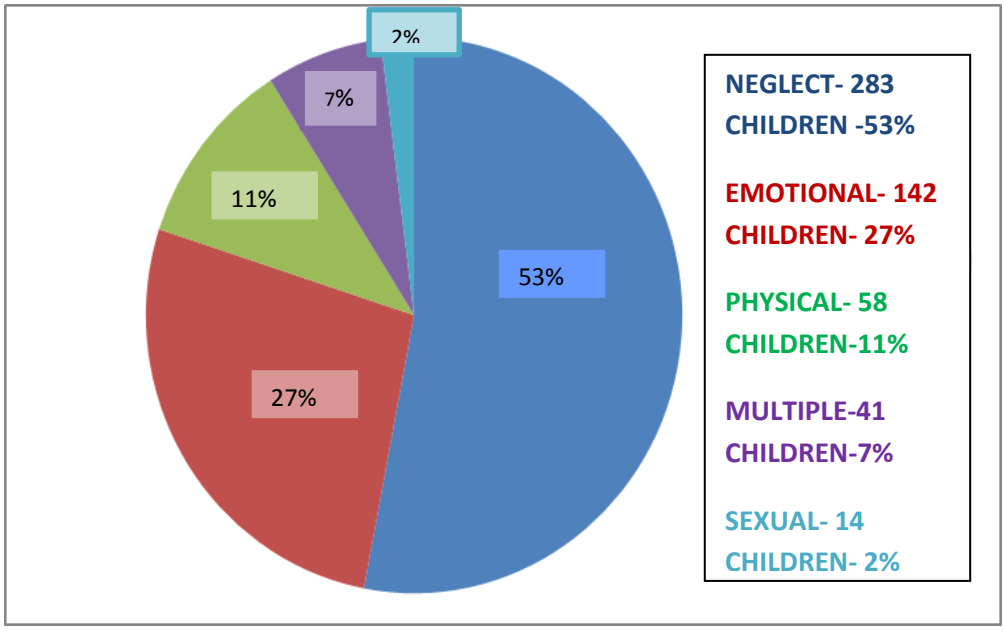
noted that, *"…in a small minority of cases, independent review is not challenging and proactive enough to ensure that plans progress effectively."*

6.9 At the time of writing this report, a piece of audit work had been completed by the Safeguarding Manager on the 10 children (which equated to 5 families) where their Child Protection plans had exceeded 18 months. The analysis found that in 3 of the 5 cases there had been a drift in the Pre Proceedings Protocols and in 2 of these conferences this was challenged by the Conference Chair within the conference and by completing Quality Assurance Alerts. 1 family was kept on a plan as the conference members wanted to see a longer period where the family had sustained the changes, however this is debatable as this could have been monitored under the Child in Need Processes.

6.10 In addition, there is a process to systematically review cases where children are subject to Child Protection Planning for 12 months and the audit will be completed quarterly and the findings will be shared with the Performance Team along with the Conference Chairs to consider any themes that have been highlighted and to ensure that exit planning is in the early planning stages with the intention of this becoming embedded into the body of the conference itself working towards the family's Safety Goals.

Child Protection Plan Categories of Risk

6.11 There are four main categories of risk that can be used as a determination of the primary risk factor for the child when subject to a child protection plan. In 2017-2018 the breakdown of categories used for the 538 children subject to a plan was Neglect 283 (53%), Emotional 142 (27 %), Physical 58 (11%), multiple 41 (7%) and Sexual 14 (2%).



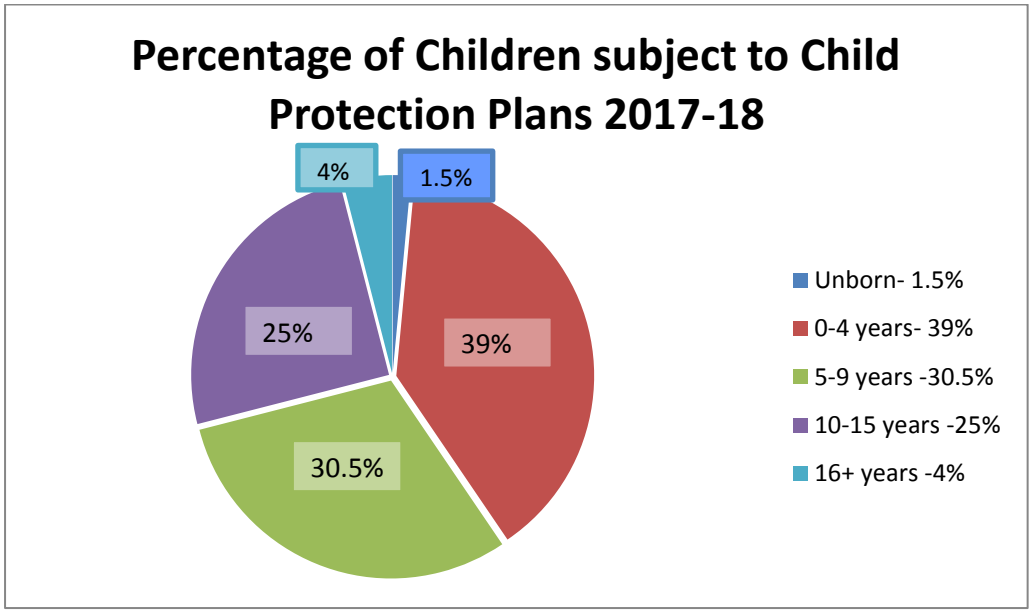
6.12 This data highlights that neglect is the primary category used and this is a reflection of the work undertaken from Early Help through to Children's Social Care of the impact sustained neglect has on the lived experience of the child and their future opportunities. At the other end of the scale sexual abuse is only representing 2% which is significantly under represented. This highlights concern of how risk of sexual abuse is being identified and critically challenged within assessments and how it is being presented and challenged in case conference. It is recognised that 7% of plans had a multiple category applied and this does not break it down to the categories used. Therefore analysis is needed to identify what percentage of multiple cases represents sexual abuse as a risk factor.

6.13 The Conference Chairs have continued to address and be mindful of having multiple categories of risk used in Child Protection plans. There has been a significant reduction in the use of multiple categories from 109 (2016-17) to 41 (2017-18) although there continues to be a concern that its continued use is impacting the identification of need from a departmental commissioning perspective and more importantly is making it less clear for children and families as to the primary presenting concerns, which is not in keeping with Signs of Safety methodology.

Child Characteristics

6.14 The age range of children subject to a Child Protection Plan remains a similar distribution as reported in previous periods; however the unborn children subject to Child Protection plans have reduced and the 0-4 years olds section has increased. This will be investigated to check that assessments of unborn children are being completed at the most appropriate time and early enough that an appropriate plan is being put in place at the earliest opportunity.

Age	Percentage of children subject to Child Protection Plans 2016/17	Percentage of children subject to Child Protection Plans 2017/18
Unborn	6.7%	1.5%
0-4 years	37.6%	39%
5-9 years	30.7%	30.5%
10-15 years	22.6%	25%
16+ years	2.4%	4%



6.15 The gender of children subject to Child Protection Plans for this reporting period is Female 49% and Male 51%.

6.16 The ethnic profile of children subject to Child Protection plans also remains fairly consistent to previous years with 88% of children being of White origin and the remaining 12% distributed across Black and Minority Ethnic (BME) backgrounds with those of Asian/Asian British accounting for most.

6.17 Historically, the data in Leicestershire regarding numbers of children with a disability subject to a child protection plan is lower compared to national percentages, but has risen to 23 children due to more accurate recording.

Conference Performance

6.18 For the reporting period 2017/18, there were 932 Child Protection Conferences and only 22 (2.5%) had 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 Service; for example, lack of agency attendance is taken up with agency leads.

6.19 Main reasons for conferences not being able to go ahead at the time are recorded in the table below and where unspecific information has been reported, for example social worker not available, the accuracy will be improved in future reporting.

Number of conference not being able to go ahead at the time was.	Reason.
1	Lack of an interpreter
1	When the ICPC was requested it was already out of date
3	Lateness in the request for an ICPC
3	Parent not available, and in one case had been hospitalised
3	No professionals attended
2	Family had moved and the Local Authority were waiting outcome of a receiving in conference.
3	Social Worker not available.
1	To move to be in term time,
1	Moved earlier due to baby birth
1	Following the outcome of court
1	Snow
2	Unknown reason

6.20 The timeliness of Review Conferences over this reporting period was good with 97.1% convened within statutory requirements; however this is a slight decrease from the 100% in the previous reporting year. Initial Child Protection Conferences figures were also good at 95.1%, although again a slight decrease to the 96.4% in the previous reporting year.

Conference Records

6.21 Distribution of child protection conference records continues to be very timely, largely as a result of a collaborative approach with the team that provides administrative support for conferences.

6.22 The majority of records, along with a copy of the Child Protection Plan, are distributed within 5-10 working days of the conference taking place. It is highlighted that there is not a data reporting process to provide specific data regarding timeliness. This has been rectified and in 2018-2019 we will be able to detail timeliness and issues of delay. In addition to the full records, 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, have 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.

6.23 It is important to note the contribution from the clerks whose professional skill and diligence have ensured a continued high standard of recording. Capacity issues with regards to the IROs and Admin are referenced and considered in more detail within this report.

6.24 The service strives to provide the same conference chair for all conferences for a family but this has continued to be a particular challenge over this

reporting period, and 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 Conference Chair will be needed but on the whole, the additional capacity anticipated in the service 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.

6.25 When a child or young person has been subject to Child Protection planning and becomes accommodated into local authority care within this Child Protection planning period we endeavour as much as possible to keep the allocation with the same IRO as the family already know them and the IRO has knowledge of the child/ren's journey into local authority care.

6.26 There will also be consideration to ending the Child Protection planning to prevent dual planning for children and young people once they have been accommodated into local authority care. This cannot be completed outside of a Child Protection Conference but all attempts are made to minimise the number of meetings for both family and professionals.

Social Work Conference Reports

6.27 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 Child Protection Conference is to be with the parent and the Conference Chair at least 3 working days in advance.

6.28 It is essential that parents/carers have the time to digest and consider the information contained in the 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.

6.29 Performance in this area has continued to be a challenge for practitioners for some time; it was highlighted as a concern in the previous annual report. However, there has been evidence of improvement compared to the previous reporting year, where it stood at between 42% - 49%, and from August 2017 until March 2018 of this reporting period, performance for conference records stood at 69%.There is still room for further improvement but it is of note that fewer parents are receiving reports on the day of conference than previously.

Consultation

6.30 The Conference Chairs and managers continue to offer consultation to the locality social work teams in situations that might be more complex or 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.

Agency Contribution & Participation

6.31 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.

6.32 It is unfortunate that over this period the agency participation is not fully recorded for the whole year .This is due to the computer systems changing, so it is not possible to report annual figures. The LSCB has convened a task and finish group to look at professionals attendance at conferences and make recommendations for improvement.

Implementation of Signs of Safety Child Protection Conferences

6.33 Since July 2015, all Child Protection Conferences in Leicestershire have been delivered using the Signs of Safety approach and Conference Chairs continue to develop and improve their skills 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 Safeguarding & Improvement Team Manager who 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 IROs development practice days with the Signs of Safety trainer.

6.34 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 2018/19 and is part of the learning audit framework within the Safeguarding and Improvement Unit (Appendix E)

6.35 In line with these planned improvements and what is happening across CFS as part of the continuous improvement plan “The Road to Excellence” we will ensure that the child is given a voice and if this is not directly within the meeting then the Conference Chair will ensure that this comes through from direct work being completed with the child. Completing the CP Conferences using the Signs of Safety Methodology ensures that the conference is a floor whereby the process is inclusive of the family and is completed with them.

6.36 There continues to be evidence of some good quality CP plans that were SMART, however it was not a consistent pattern and all of our plans need to be outcome focussed. The main challenge was to ensure that all CP plans identified clear bottom lines for the family, and that all plans set out clear outcome focused objectives with timescales. Both of these issues formed part of the work with IROs in the proposed Development Day, as well as IROs

observing and sharing each other's practice. This will continue to be supported moving into the next reporting period.

6.37 Work on practice standards as part of the departmental improvement plan will assist greatly in taking this forward over 2018/19.

Feedback

6.38 The IROs have continued to provide direct support and advice to Social Workers on the Signs of Safety approach. This has been welcomed, as evidenced from the communications received from Social Workers and Team Managers in supporting case discussions and skilfully managing the Child Protection Conferences.

6.39 There has been continued collaboration and support with other local authorities who are embarking on the implementation of the Signs of Safety approach to Child Protection Conferences. Leicester City is embarking on embedding Signs of Safety within the conference and will be observing our conferences over the next reporting period.

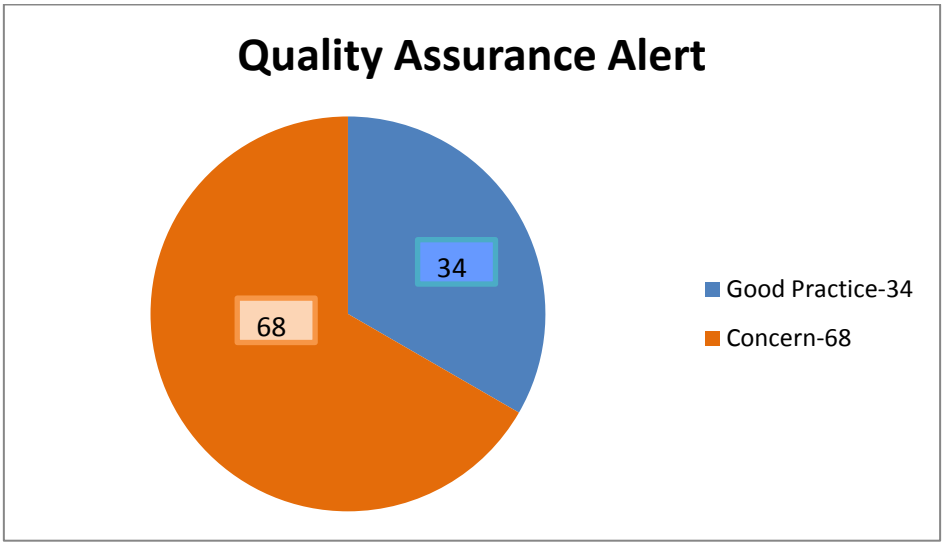
Challenges & Escalation

6.40 As referenced in the introduction of this report, IROs within the Safeguarding Team have a quality assurance role in identifying areas of concern in child protection practice and undertaking challenge where it is required. IRO Quality Assurance Alerts were 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.

6.41 For this reporting period 2017/18, there were 102 IRO Quality Assurance Alerts which is an increase from the previous reporting year at 85. 34 good Practice Alerts were raised and 68 for concern.

6.42 What is pleasing is that the amount of IRO Quality Assurance Alerts has increased (from 13 to 34); the number which highlighted concerns was slightly lower than the previous reporting year (72). Celebrating and learning from good practice is imperative to supporting consistent positive practice.

6.43 Monthly overview reports are completed 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.



6.44 Good practice examples have noted:

- Praise for the work that a practitioner has completed with a family/child/young person.
- Quality of plans/reports and preparation work prior to a CP conference.
- Good solid assessments provided to CP conference with good analysis.
- Good detailed report from the Social Worker, good communication with both parents who were challenging throughout the conference.

Concerns:

6.45 The key areas were drift and delay and timeliness and quality of the report.

Timescales:

6.46 It continues to be of concern that practitioners along with managers have not always responded to Quality Assurance Alerts and/or have not 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.

Appeals/Complaints

6.47 There have been some young people who have appealed the decision to make them subject of a Child Protection Plan in this period and they are supported by the Children's Rights Officer for Child Protection. There is a separate Annual report of the Children's Rights Officer that goes into more detail and covers children's participation and voice in child protection conferences.

6.48 There have been seven complaints made by parents/carers in this reporting period, all resolved at Stage 1.

6.49 There was one complaint from a professional regarding an IROs management of part of a Child Protection Conference; this again was resolved without it formally progressing.

6.50 **What needs to happen over 2018/19:**

- It remains the ambition of the Safeguarding and Improvement Unit to continue to 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 2018/19. The impetus will be to sharpen delivery through best questions, exploring family networks, and family based plans (with clear evidenced trajectories) based on best principles from the Signs of Safety 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.
- Safeguarding Manager to monitor Initial Child Protection Conference activity particularly where children are not made subject to Child Plans, and complete a quarterly audit.
- Safeguarding Manager to monitor the repeat planning activity and complete a quarterly audit.
- Safeguarding Manager to monitor length of Child Protection Conferences activity, and complete a quarterly audit.
- Safeguarding Manager to monitor Initial/Pre-birth Child Protection Conference activity particularly auditing if the unborn/child has been presented to conference at the most appropriate time, and complete a quarterly audits.
- Safeguarding Manager to complete regular observations of Conference Chairs during Conferences, also Conference Chairs to have the opportunity to observe each other.

7. Harmful Sexual Behaviour

7.1 The lead for Harmful Sexual Behaviour over the reporting period was one of the Team Managers of the Safeguarding & Improvement Unit (SIU). There has been continued involvement within the developments in this field throughout 2017/18, and also heightening the profile and support needed for these young people. The manager has been involved in a significant amount of development work that has been undertaken across CFS.

7.2 A task and finish group was established to develop the operational response to Harmful Sexual Behaviour (HSB), made up of key managers and practitioners from CFS including HSB lead from SIU, specialist therapeutic worker, along with Police Child Abuse & Investigation Unit and Learning & Development 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.
- More training throughout CFS for staff at all levels in the assessment and referral for children and young people exhibiting HSB.
- This group has been chaired by SIU Head of Service and focussed on the future developments at a strategic level. A sub group continues to address the training and developmental gaps across the work force.
- This group also concentrated on developing and updating the HSB Policy and it is hoped that this will be completed by September 2018.

LCC in the context of National Developments

7.3 The Notion of 'Harmful Sexual Behaviour' has a dual 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. It is pleasing to report that the terminology Harmful Sexual Behaviour has been widely adopted and recognised by staff members across CFS as well as our partner agencies.

Training & Workforce Development

7.4 Staff understanding of HSB thresholds and procedures continues to need 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.

7.5 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 young people with a learning difficulty or developmental disorder which may have inhibited their sexual maturity.

7.6 AIMS 2 is a nationally recognised risk assessment tool for children over the age of 10 years who are displaying HSB. The risk assessment assists practitioners to identify a suitable intervention programme. In the last reporting year 2016/17 only 2 workers throughout CFS were trained in AIMS 2, which is in contrast to now where there are over 60 Social Workers who are AIMS 2 trained. Although there are no IROs who are currently AIMS 2 trained, 4 staff from the team will be completing this training in September 2018 and these will be the IROs who will be chairing the HSB meetings.

7.7 Even though there are over 60 Social Workers who are trained in AIMS 2, in the last reporting year the majority of AIMS 2 risk assessments are being

completed by Youth Offending Service workers, when there was already an allocated Youth Offending Service worker.

7.8 What needs to be recognised by managers from the teams where there are workers who have completed the AIMS 2 training is that these Social Workers need to be given permission to use this qualification and work alongside the allocated social worker in completing this risk assessment.

7.9 As AIMS 2 is a risk assessment tool, to further deepen the direct work that can be completed with the young people who are displaying HSB the IRO that are AIMS 2 trained need to complete the Good Lives course which is the intervention part.

7.10 AIMS training for Managers across CFS is available and this 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 have yet to complete this training, which has left a gap in knowledge. Consideration is being given to providing bespoke training to these managers, as it is essential in order to support the workers in identifying appropriate support packages when completing these Assessments.

7.11 Under the guidance of the chair and strategic lead for the HSB development group, the LSCB policy and procedures for HSB for LLR are being amended to 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 HSB.

7.12 The HSB task and finish group has identified that there continues to be a lack of understanding, not just within CFS, which means that children are not always identified in a timely way and on some occasions have been left without a safe plan in place. Some 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.

Harmful Sexual Behaviour Meetings

7.13 Over the reporting period, the HSB lead has received 38 referrals and of these 9 HSB strategy meetings were held and the other 29 did not meet the criteria. 2 of the children subject to a HSB meeting were children in care. Of the 38 referrals that were received, 33 were reported to be of White/British ethnicity, 2 were reported as being white/any other white background, 1 mixed any other mixed background, 1 mixed white and black Caribbean and 1 not stated.

7.14 For children who were referred but did not meet the Red/Amber threshold, recommendations from the HSB meeting looked into basic intervention from the allocated social worker.

7.15 Historically HSB meetings have been in the main one off meetings and it is our vision that we want there to be a full review of the HSB Action, and for there to be review HSB meetings until all people part of the HSB meeting feel that there is the right plan in place for the HSB meetings to cease, and professionals can continue to work with the plan.

7.16 It is important that the HSB meetings run alongside any other plans such as child protection planning or care plans and that they inform each other, and there is not any further weight offered to any other plan.

7.17 Leicestershire has embedded Signs of Safety into most areas of the interventions with young people and their families, although this is not the case for HSB meetings. The HSB lead has had discussions with the Principal Social Worker who has agreed to work with all of the AIMS 2 trained IROs and make the process more aligned with the signs of safety methodology.

HSB lead role

7.18 The HSB lead role has sat in SIU for the past 11 years - this has consisted of 1 IRO that was seconded to a Team Manager role in the SIU, chairing HSB meetings and offering consultation to the CFS staff.

7.19 The impact on the HSB lead has been significant and the role has needed to expand accordingly, now encompassing more consultation around thresholds, processes and procedures; chairing HSB meetings, providing a record of the meeting; quality assurance activity and other activities around development work and input to training and workforce development. It was reported in the last annual report that the HSB lead role needs to be reviewed to ensure that the capacity to offer an effective service remains paramount. There is a plan for this and the lead role for HSB is with the Safeguarding Manager and there will be 4 IROs who will be AIMS 2 trained and will chair the meetings, complete the minutes and action plan of the meeting itself.

7.20 Whilst it is great that young people will have an allocated IRO it will have an impact on the IRO case loads.

Training Planning

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

i. Brooks Traffic Light Tool training to continue to be rolled out to all CFS workers
ii. There will be purchased AIMS 2 training for 3 IROs 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.

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

i. Joint review and update of LLR LSCB procedures for HSB to include changes to procedures/process and language.
ii. Staff group training/briefing on updated procedures to be undertaken.
iii. 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
iv. 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.

8. Recommendations 2018-2019

8.1 This Annual Report to be tabled for CFS Overview and Scrutiny Committee on 5 November 2018 and then Corporate Parenting Board on 22nd January 2019

8.2 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 2018-19. IROs to continue to demonstrate fidelity to Signs of Safety Methodology and deepen their skill and practice using these opportunities

8.3 IRO Service to seek to improve the participation of children and young people in the LAC Review/process and this will be supported by the consistent implementation of Signs of Safety within this forum. 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

8.4 Subject to capacity issues being addressed, IRO Service/SIU Admin to evidence improved performance over 2018-19 as regards timeliness of production and distribution of LAC Review records.

8.5 Operational teams to evidence improved and sustained performance over 2018-19 as regards timeliness/availability and quality of social work reports, updating assessments and plans for LAC Reviews and child protection conferences.

8.6 Noting the impact that capacity has on 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. Particularly regarding children subject to child protection plans where the footprint of IROs is less visible.

8.7 All IROs need to ensure that they are effectively utilising the Quality Assurance Alert to highlight both concerns and positive practice. The

escalation of the QA needs to be consistently applied to ensure impact is effective and timely.

8.8 IRO Service to provide quarterly IRO QA Alert overview reports to SMT and Performance Meetings.

8.9 Operational teams to ensure practitioners and managers respond and in a timely manner to IRO QA Alerts

8.10 IRO Service to work closely with Cafcass over 2018-19 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.

8.11 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.

8.12 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.

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

8.14 IRO Service to evidence consistency of chair for child protection conferences as far as capacity will allow.

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

8.16 HSB Training Programme as outlined in Section 7 to be implemented

8.17 HSB Task & Finish Group to take forward strategic developments outlined in Paragraph 7.22

Kelda Claire
Service Manager

Hayley Binley
Safeguarding and Improvement Team Manager: Performance and Corporate Parenting Lead

Kara Walne
Safeguarding and Improvement Team Manager: Safeguarding Lead

Quality Assurance learning framework for Safeguarding and Performance Service 2018-2019

Month	Quality Assurance Activity	Named worker	Purpose of Quality Assurance Activity Service Goal
Quarter 1 **April**	Observation of Case Conferences	Kelda Claire/ Team Managers	To identify learning needs and themes Preparation, engagement of family and SOS, challenge. SOS is being consistently and effectively implemented. Resulting in effective and meaningful Child Protection Plan
May	(Service Specific audit) Audit of health within ROA	Kelda Claire and Claire Turnbull (LAC named nurse)	Health needs are clearly represented within the record. They are child specific and consider early years experiences and future needs
June			
Quarter 2 **July**	(Service Specific audit) Audit of Child protection plans 18 months + Audit of repeat child protection plans	Kara Walne	To identify themes IRO Tracking and challenge Use of Neglect toolkit, analysis tool for repeat plans used.
August			
September	(Learning Audit) Peer audit of Care Plan	IRO's	To highlight good practice To evidence SOS being embedded in practice To highlight the voice of the child and impact Care Plan's to be SMART
Quarter 3 **October**	(Service Specific audit) Audit of health within ROA	Kelda Claire and Claire Turnbull	Health needs are clearly represented within the record. They are child specific and consider early years experiences and future needs
November	(Service Specific audit) Audit of Child	Kara Walne (Team Manager	To identify themes IRO Tracking and challenge

	protection plans 18 months + Audit of repeat child protection plans		Use of Neglect toolkit, analysis tool for repeat plans used.
December	Observation of Case Conference	Kelda Claire, Kara Walne and Stuart Jones	To identify learning needs and themes Preparation, engagement of family and SOS, challenge
Quarter 4 **January**	(Learning Audit) Peer audit of Care Plan	IRO's	To highlight good practice To evidence SOS being embedded in practice To highlight the voice of the child and impact Care Plan's to be SMART
February	(Service Specific audit) Audit of health within ROA	Kelda Claire and Claire Turnbull	Health needs are clearly represented within the record. They are child specific and consider early years experiences and future needs
March	(Service Specific audit) Audit of Child protection plans 18 months + Audit of repeat child protection plans	Kara Walne (Team Manager	To identify themes IRO Tracking and challenge Use of Neglect toolkit, analysis tool for repeat plans used.

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