LEICESTERSHIRE COUNTY COUNCIL

CHILDREN & FAMILY SERVICES

Safeguarding & Performance Unit

Independent Reviewing Officer (IRO) Service Annual Report 2018 -2019

Leicestershire County Council

Content

Introduction

The Annual Report for the Independent Reviewing Officer (IRO) sets out the current performance for the service in 2018-2019 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 against them. 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.

The IRO Service in Leicestershire sits within the Safeguarding & Improvement Unit (SIU). 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.

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. Throughout this report both the conference chair and looked after review chair will be referred to as Independent Reviewing Officer (IRO).

The quality assurance role of IROs is critical to the development and improvement of the intervention that we provide to children and families and the impact that we have on the outcomes for children. IROs 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.

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. Through these changes the IRO has an effective, independent and holistic oversight of the child's case and ensures that the child's interests are protected throughout the care planning process.

This oversight provides opportunity for independent challenge in decisions identified as not being in the best interests of the child or where drift or delay has an impact on outcomes. 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.

In Leicestershire, as the IROs also undertake the Conference Chair role, the expectation is that the IRO will apply the same quality assurance approach for children subject to child protection conferences and child protection plans. IROs chair child protection conferences and have oversight of child protection plans and the progress of such and challenge when performance and practice concerns are identified.

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 2018 to March 2019. It is an evaluative report considering how effectively the Safeguarding Until has fulfilled the responsibilities of its role and the impact that this has had on children and families of Leicestershire. It is an opportunity to pinpoint areas of good practice and those in need of development and improvement. It highlights emerging themes and trends, providing information that contributes to the strategic and continuous improvement plans of the local authority. The performance measures used to measure success are both qualitative and quantitative data from all areas of quality assurance undertaken throughout children's services

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).

Context

The legal framework and statutory guidance for the IRO role for children in care is set out in the Care Planning, Placement and Case Review (England) Regulations 2010 (amended 2015) and the IRO Handbook 2010.

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.

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.

The National Children's Bureau (NCB) research 'The Role of the Independent Reviewing Officers in England' (March 2014) provides a wealth of information and findings regarding the efficacy of IRO services. The foreword written by Mr Justice Peter Jackson; makes the following comment:

'The Independent Reviewing Officer must be the visible embodiment of our commitment to meet our legal obligations to this special group of children. The health and effectiveness of the IRO service is a direct reflection of whether we are meeting that commitment, or whether we are failing'.

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

IRO Service

Safeguarding and Improvement Unit

1x FTE Service Manager

2x FTE Safeguarding Managers

13.06 FTE IRO

There are significant benefits of the IRO service being located within Children's Social Care with clear guidelines to practice which support the effectiveness of their maintained independence. The position allows IROs to have a good understanding of the context in which the Local Authority operates and understands the changing demands and pressures in the Department, including the impact of recruitment and retention.

IROs are able to build constructive working relationships with social work teams which are vital to their quality assurance role in enabling the oversight of the strengths and needs of the department. This in turn enables contributions to improvement activity which have a direct impact on improved outcomes for children and families.

There have been a number of positive changes within the Safeguarding and Improvement Unit during 2018-19 with permanent appointments to the two Safeguarding Manager positions and appointment to four permanent IRO roles. In addition to these staff changes there have been continuing pressures, with the Safeguarding administration team having experienced a number of ongoing difficulties with staffing levels. The Safeguarding administration team is imperative to ensuring that the IRO service effectively meets its statutory duty. The difficulties have been addressed through additional staffing being put into the team.

Within the Safeguarding and Improvement Unit a weighting process is applied to analyse caseloads. This process takes into account the two different roles of the IROs; chairing Child Protection Conferences and Review of Arrangements and identifies each LAC case as 1.5 cases and CP cases as 1.

The IRO handbook guidelines refer to caseloads for IROs (only referring to the role with Looked After Children) as 50-70 cases. The application of the weighting process makes this 75-105 cases. Over 2019-18 caseloads have continued to be higher than these recommended guidelines with the average caseload being 110 (with weighting process applied). In order to address this two additional IROs have been agreed, which will support maintaining a case load in line with the IRO handbook. While active recruitment takes place agency IROs have been in place. The increasing numbers of children in care and children subject to a child protection plan will continue to have an impact on the assessment of capacity. This will need to be assessed and analysed moving forward.

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)

During 2018-19 the IRO service has continued to utilise the bespoke training in Signs of Safety which has been provided as a part of the England Innovations Project (EIP2). This training supports the quality assurance role of the IROs and the progress of embedding Signs of Safety throughout all areas of the work within CFS.

These additional training opportunities are continuing into 2019-20 as the department continues to embed the Signs of Safety methodology into its culture and practice.

IROs continue to be enthusiastic in their role as practice leads and regularly attend and contribute to the 'Practice Lead' development sessions. 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.

IROs play a significant role in the development and delivery of high-quality interventions to children in care and in need of protection. The IRO Service in Leicestershire remains committed to this responsibility. 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.

Importance of the voice and views of our children

Advocacy

Advocacy provision in Leicestershire is provided in house through our Children's Rights Officers (CRO) based in the Corporate Parenting Team. The aim of the Children's Rights Service (CRS) is to provide advocacy to empower children and young people; supporting them and ensuring that their voices are heard in decision making. Children and young people may be given additional support of a CRO to attend their Review of Arrangement meetings (ROAs), child protection conferences (CPCs) & other meetings about them so their voices can be clearly heard.
IROs routinely check that children and young people know about advocacy and how it can support them in having a real say in decisions affecting their lives.

E aged 17
I couldn't of asked for a better IRO , She always looks out for me , Makes me laugh , Takes me for coffee , Always polite.
Very chatty and giggling all the time. So Thank u for all of the support u have helped me and my dad build a good relationship up again

Coz not everyone listens to what the kid wants. The CRO knows what's best for the child". K, 15

My IRO let me think about my religion. They gave me time to think it through and make my own decision S,11

Leicestershire County Council

What's working Well/ What are we worried about against our 2017/18 priorities

Overall Performance

	2017-18	2018-19
Timeliness of ROA	99.4% (8/1350)	98.9% (15/1388)
Participation in ROA	92.3% (1,038)	86.5% (1,049)
Social Worker Assessment 24 hours before review	51.1%	76%
Repeat child protection plans	19%	15.2%
Multiple Categories (child protection plans)	7% (41)	10% (51)
Review child protection conference timeliness	97.1%	97.3%
Initial child protection timeliness	95.1%	91.5%
Social Work reports to child protection conference within LSCB timescales	69%	75%

Strengths – What is Working Well?

Average performance for the year in relation to timeliness of Looked After Children (LAC) Review of Arrangements remains high at 98.9%, as is the case for timeliness of Review Child Protection Conferences (97.3%) and Initial Child Protection Conferences (91.5%). It is recognised that this is a slight drop from 2017-2018 but remains high and well in line with statistical and national data. Service Managers have oversight of all cases that are going to be out of timescale to ensure robust decision making and learning is shared.

Repeat planning continues to maintain at a low figure. 2018/19 ended at 15.2% of child protection plans being a repeat plan in comparison to our statistical neighbours (21.8%) and England average of 20.2%. There has been work within the IRO service to support robust assessments and ensure SMART (Specific, Measurable, Achievable, Realistic, Timely) step down plans are in place for the ending of CP plans. In addition, the IROs complete an analysis tool for all incoming repeat plans to enable learning moving forward.

The use of multiple categories of risk in child protection planning has seen a slight increase in 2018/19 from 2017/18 from 41 to 51. Despite this increase, in comparison to 2016/17 when it was 109 and had been raised as an area for improvement, the current figure continues to be a maintained reduction. The IROs have continued to ensure reflection and analysis for those cases where a multiple category is identified as appropriate.

The development of the process to respond to children who display Harmful Sexual Behaviours (HSB) has continued to make headway. An HSB process has been developed on mosaic which has enabled initial assessment of HSB to be more visible and also aided a more consistent and monitored approach. There has been

training of 4 IROs in AIMS 2 (an assessment model for young people who have displayed sexually harmful behaviour) to enable broader provision of meetings and the meetings have been developed to offer a review process in line with that used for child protection. This ensures a robust review process for children and families to receive the right level of support until enough safety or change has been evidenced. There is future development for 2019/20 to build upon the strengthened response to HSB.

The 2 additional IRO posts created from the 2017/18 review have been successfully recruited to with experienced and suitably qualified practitioners. Additional staffing has also been agreed for 2019-20, which highlights the continued support of senior management for the important role of IROs in both child protection and for our looked after children population.

During the reporting period the IROs have had a programme of audit work within the Safeguarding Unit to support the critical role in supporting quality assurance and improvement. There has been additional quality assurance work undertaken outside this programme following the identification of themes and responding hypotheses. The impact of this work is that the unit knows itself well and areas of improvement can be identified both within the unit and for the wider service and action taken to respond in a timely way.

Challenges – What are we worried about?

The performance of participation of children within their Review of Arrangements remains a key area of development. The number of children (over age 4) participating in their reviews has increased from 1,038 (2017-18) to 1,049 (2018-19). Due to the increase in our looked after population the percentage shows a slight reduction from 92.3% to 86.5%. Although this baseline figure remains positive we are aspiring to improve.

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.

As a result of the performance within the previous year IROs were directed to complete Quality Assurance alerts if reports had not been received within timescales prior to meetings taking place. This has shown an improvement in reports being received prior to LAC reviews increasing from 51.1% (2017-18) to 76% in 2018-19. There has been a similar improvement with reports received prior to CP conference from 69% to 75%. For the remaining, the reports were tabled on the day of the meeting. This a key area of performance being driven within Children and Family Services and whilst this is positive to see, it remains a key area of improvement work.

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 so that this demonstrates a visible and timely impact on case planning.

There has been positive progress made in minimising the delay in minutes being produced after meetings. There is robust practice in child protection conferences of all participants leaving the conference with the 'mapping' of the meeting and the 'next steps'. Also, IROs consistently provide the actions of the LAC review within 5 days of the review.

Nevertheless, it is recognised that there is further work required to support all IROs completing LAC records in a consistently timely way. Managers are proactively supporting those staff who continue to show delays in recording being completed in supervision and through the allocation of protected administration time for IROs. The critical need for timeliness in the distribution of records of Reviews is fully recognised and understood by the management team within the Safeguarding Unit.

Positive progress has been built in, in relation to the Quality Assurance (QA) Alert process. This has led to an increased number of positive alerts to support our learning from good practice. The overall impact of the QA process needs more analysis and a more systematic tracking of responses to ensure impact. This will be a focus of work in 2019/2020. IROs have not always escalated concerns when a response is not satisfactory or remains outstanding. This lack of focus can mean the impact of the process is reduced. Work is taking place to ensure that the process is systematically implemented beyond the first QA and themes for positive and negative QAs are more effectively analysed and utilised in development work throughout CFS.

Areas for Improvement – What needs to happen

Participation of young people: We aim to develop a broad range of methods, including tools, to support the participation of children in their Review of Arrangements. This includes consideration of the use of technology to support inclusion. This work is being led through the Corporate Parenting Board, 'you said, we did' activity. This includes the development of a task and finish group of young people and IROs to create an expectations statement for inclusion, to re-launch the views workbook to ensure voice is captured before the review and to develop a feedback to ensure this supports further development and improvement. The measurement of our success will be drawn through the participation performance data, feedback from young people and accountability through the Corporate Parenting Board.

QA alert process: A priority is to continue work to develop the Quality Assurance Alert process as a Mosaic step. This will allow better ability to track the alerts to completion and ensure that the process is timely and effective. This will also allow better performance data to be captured and build the alert process into the learning cycle more systematically. Until this process is in place, 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. Initial work to embed this approach is in place.

Recording and distribution of records: The lack of consistent progress with ensuring timely recording distribution of records needs to be addressed and improvement sustained. To achieve this, managers will have robust oversight of

timely recording and caseload analysis within the team and if necessary ensure that senior managers are aware of pressure points during the year. A new process has been introduced so that Actions from Review of Arrangements records are uploaded to Mosaic within 5 days. In addition, IROs are also uploading their own records and it is planned that we will measure performance and provide reports on both areas in 2019/20. This will give a more accurate picture of both IRO and administration team improvements.

Social work reports to conference: IROs to continue to support and drive forward the improvements in the timeliness of social work reports prior to LAC reviews and CP conferences.

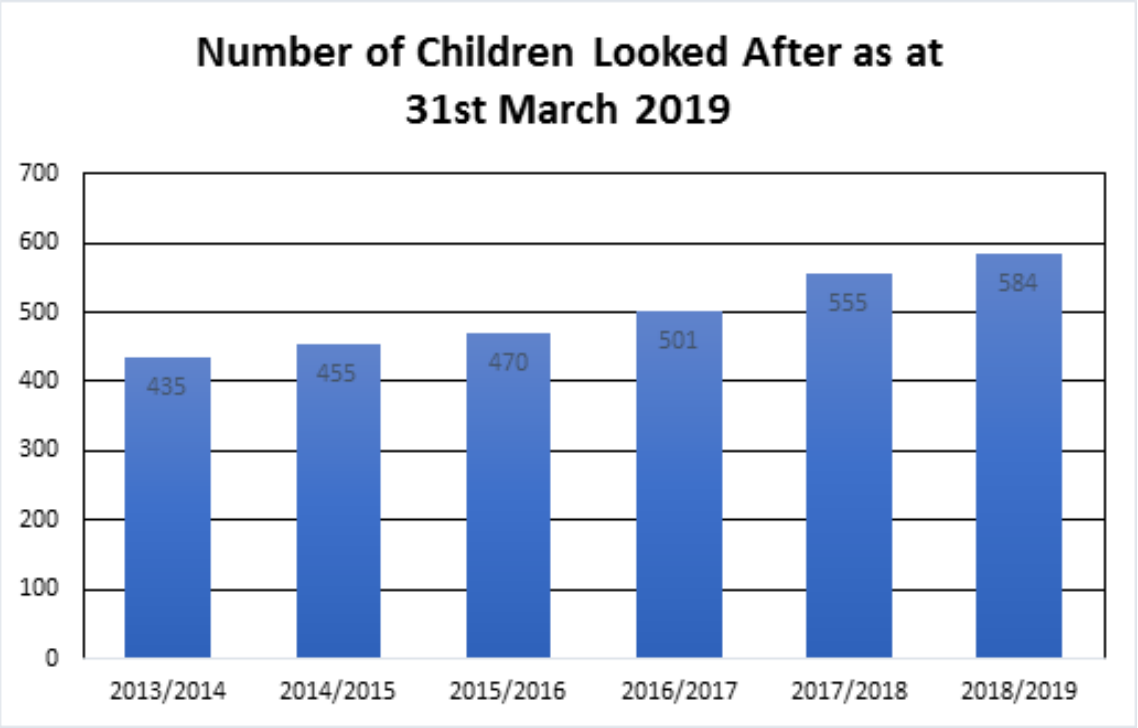
IRO role in improvement to continue to produce an analysis to Safeguarding and Improvement Unit (SIU) Team Managers in cases of repeat CP plans. This analysis, in addition to the quarterly audit, will be used to develop practice and inform learning.

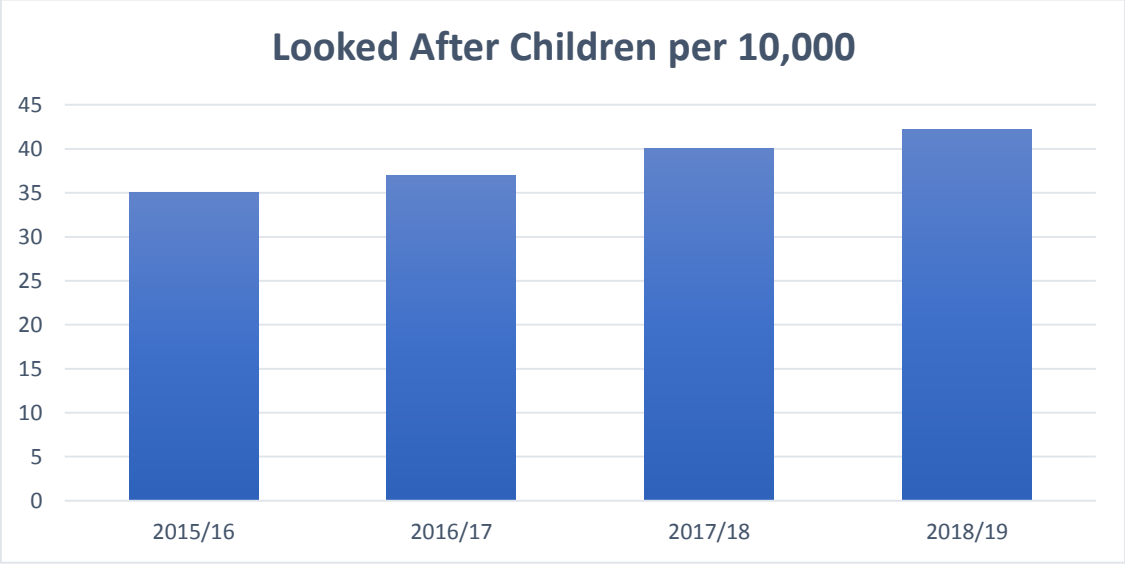
Independent Reviewing Officer - Children in Care Services

Children in Care - Review of Arrangements

As can be seen from the tables below, the children in care population in Leicestershire has increased further over 2018-19, 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 neighbour's average, it continues to remain lower currently.

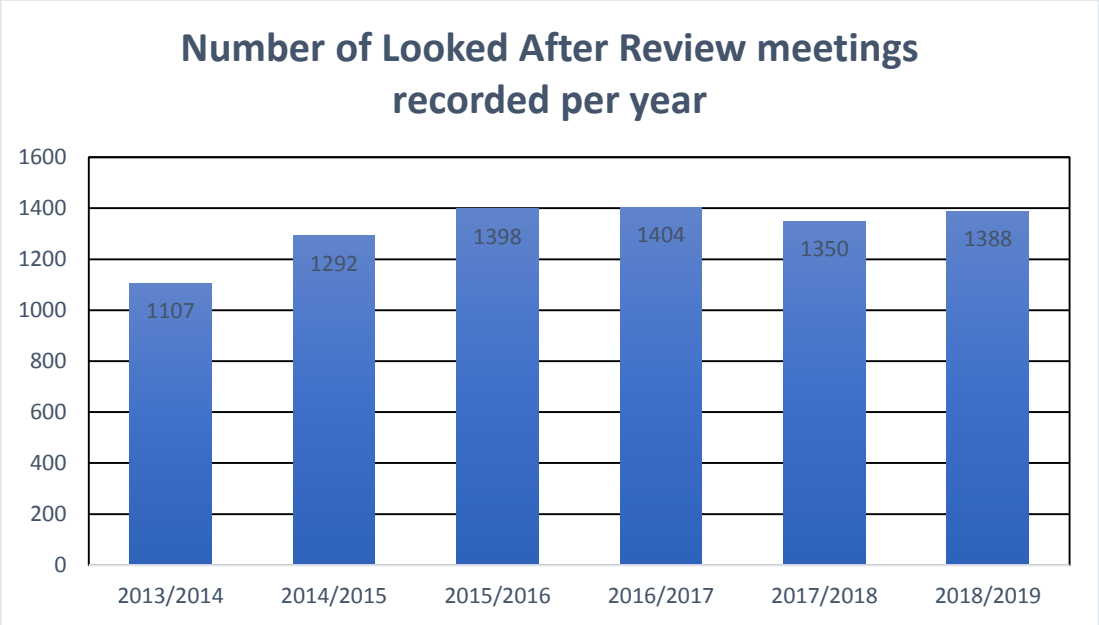
Leicestershire had 42.2 looked after children per 10,000 at the end of 2018/19, an increase from 40 per 10,000 at the end of 2017/18. The statistical neighbour average for 2017/18 was 52.5, the East Midlands average was 57 per 10,000 and the average for England was 64 per 10,000. Although the statistical neighbour's data has not yet been made available for 31st March 2019 it is reasonable to assume that Leicestershire continues to have one of the lower levels of children in care nationally.



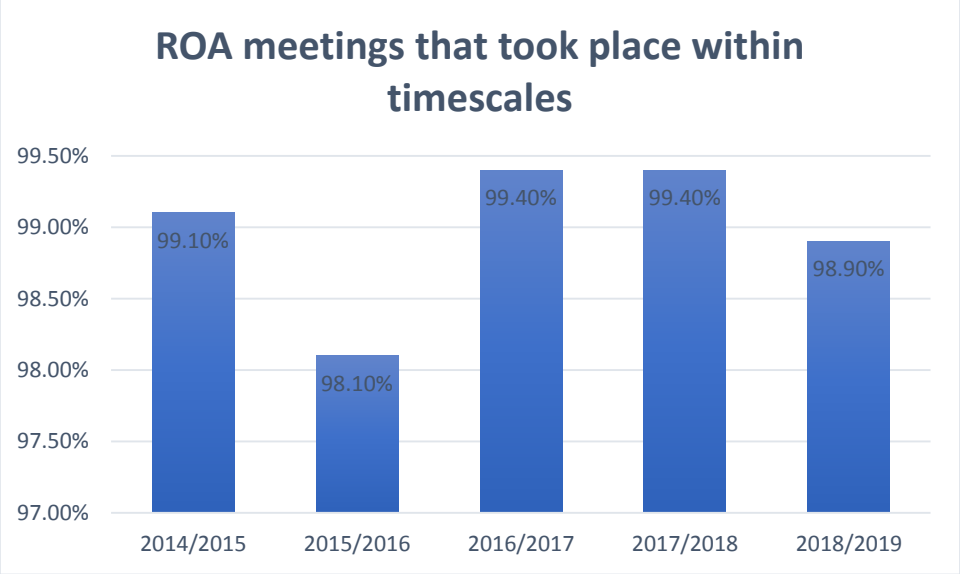


The activity generated from this increase is reflected in the number of review meetings held for children between 1st April 2018 and the end of March 2019 which totalled 1388, this is an increase of 38 meetings from the total of 1350 held between 1st April 2017 and the end of March 2018 (NB this is meetings held, not individual children's meetings, for example a sibling group of 3, whose meeting was held together would count as one meeting). It is noted that the number of review meetings was higher in both 2015/16 and 2016/17 despite there being less children in care at this time. In addition to the statutory reviews, IROs can also arrange additional meetings for a number of reasons including to review a case earlier due to concerns about drift and delay or because there has been a change in the child's care plan. A meeting is required following change of placement. The lower number of reviews

could be an indication that there has been less concern to require an early review or less unplanned change to children's care plans over the last two years.



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



Although performance is slightly down on the previous year, 98.9 % of meetings held in timescale can still be regarded as strong performance. From a total of 1388 meetings which took place during this time period, 15 were out of time scale. This compares with 8 out of timescales in the previous year from a total of 1350 meetings.

The Safeguarding Unit keep an 'out of date log' to record the reason for each case which does not take place in time. One case was late as it had originally been put back to enable the young person to complete their exams before their review took

place but unfortunately due to the change of date professionals did not receive the invitations to the re-scheduled meeting. On six other occasions the lateness was linked to either staff error or staff sickness. The Safeguarding Unit managers and IROs are mindful of the importance of ROAs being undertaken within timescales not only due to statutory requirements but also due to the impact of the family and the child, as it is their meeting and any delay could be seen as the local authority underestimating the importance of their views and concerns about their plan.

As with the previous year the most common reason that 28 Day views did not take place on time was because the Looked After Children business support team were not notified of a child becoming looked after in a timely manner. Of the eight cases referred to the Safeguarding Unit late, one case was an Adoption Reviews whereby the child's status changed from looked after in a foster placement to being placed for adoption following an ADM decision. The relevant Social Worker was on leave and no one else contacted the Safeguarding Unit to notify them of the change.

On each of the seven occasions where there was no notification of a child becoming looked after it would appear to be an oversight on behalf of the social worker, a number of who did not understand the process and the need to make contact with the Safeguarding Unit. To address this the Safeguarding Unit has now requested a step to be placed onto mosaic which will identify when a child has become looked after. This can automatically be picked up by the business support team, who will then forward to management for allocation to an IRO in good time for the review to take place. The issues have also been raised with the Team managers and service managers to ensure robust understanding and implementation of processes.

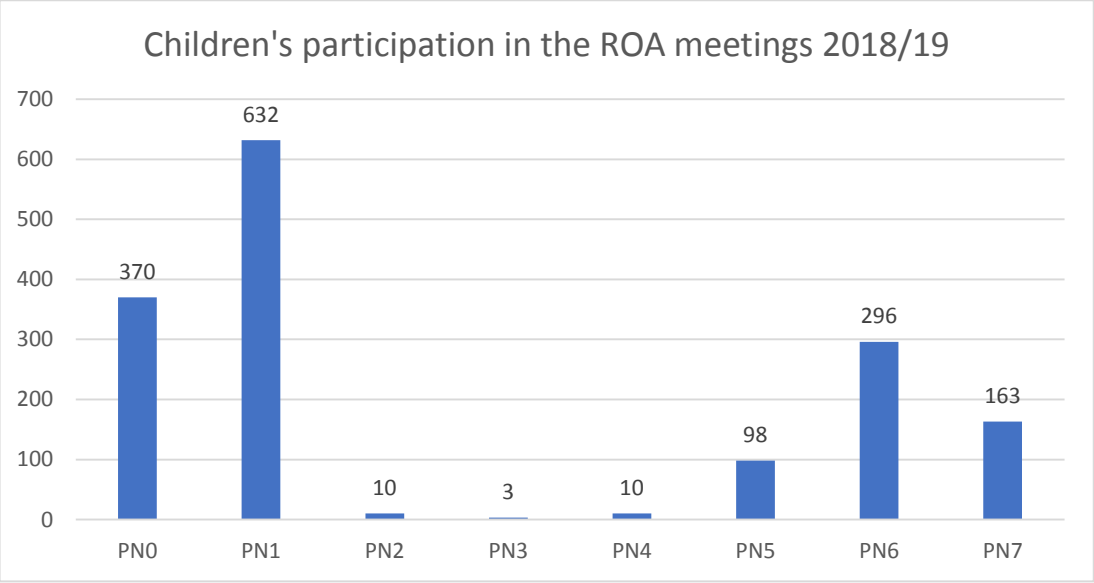
Participation

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.

Participation is defined across 7 different indicators:

	2014/15	2015/16	2016/17	2017/18	2018/19
Children under the age of 4	351	381	363	363	370
Children who attend their reviews and speak for themselves	495	522	550	554	632
Those who attend but communicate via an advocate	14	10	13	4	10
Those who attend and convey their views non-verbally	4	7	3	2	3
Those who attend but don't contribute	16	15	4	11	10
Children who do not attend but brief someone to speak on their behalf	97	74	70	52	98
Do not attend but communicate their views by another method	250	295	399	415	296
Those who do not attend/convey their views in any other way	75	100	50	87	163

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.



Children's Participation in ROAs 2014/15 to 2018/19

The number of children (over age 4) participating in their reviews has increased from 1,038 (2017-18) to 1,049 (2018-19). Due to the increase in our looked after population the percentage shows a slight reduction from 92.3% to 86.5%. Although this baseline figure remains positive we are aspiring to improve it. It is positive to see

that the percentage of children that attended their reviews has continued to increase, from 49% in 2017/18 to 52% in 2018/19.

There has been work undertaken through the Corporate Parenting Board and the Children in Care Council to look at broadening how children can participate and how they can have clear expectations of how they want their meeting to be run. It is anticipated that this drive will support an improvement in this figure and also improve the experience of our children in relation to their meeting.

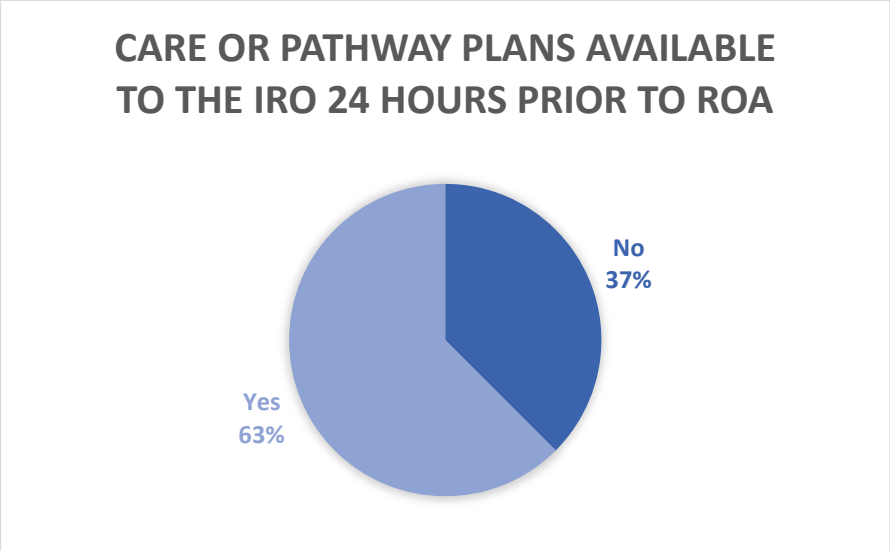
IROs have been working to make review meetings more inclusive, utilising Signs of Safety methodology and thinking creatively with our young people, including examples of some children chairing their own review and creating the review as a Power Point presentation. The Safeguarding Unit is committed to improving the active participation of our children in their review and to look at broader ways of increasing participation such as technology. This is driven from the voice of our children who have highlighted the importance and impact of being actively involved in their LAC review. Involving children in their reviews needs to continue to be promoted within the service and further development work will continue around ensuring participation is key on the IRO agenda.

As can be seen from the table above a key factor in why the overall number of children participating in their reviews has declined is due to the significant decrease in 'children who did not attend but participated in their reviews in other ways'. It is believed that the higher numbers for this group in 2016/17 and 2017/18 was in part due to the use of the participation document given to young people in advance of their ROA to capture their views. However, this has been used less in the current report period.

Following the most recent Corporate Parenting Board meeting it was agreed to relaunch this document. In addition, the Participation Officers within the Safeguarding Unit have been working with the Children in Care Council to further look at other creative ways to enable young people to engage in their reviews. This is in addition to the creative ways in which the IROs already obtain the views and wishes of young people who do not attend their reviews. This includes using communication methods many of our young people are familiar with such as email, texts, phone calls and skype. For children where communication can be more difficult, our 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.

IROs aim to have strong and meaningful relationships with the children and young people with whom they work. There remains a strong commitment to keeping in contact with them in between and prior to their reviews, although due to capacity issues, this has been a considerable challenge in this financial year. It is hoped that with the additional resources which have now been agreed by senior management IROs will be able to renew their focus on building and maintaining these relationships. This is seen as vital, as young people have routinely provided feedback at Children in Care Council meetings and at the Corporate Parenting Board on the value of knowing their IRO to enable them to use their ROA to best effect as a safe space to raise any issues or concerns that they may have.

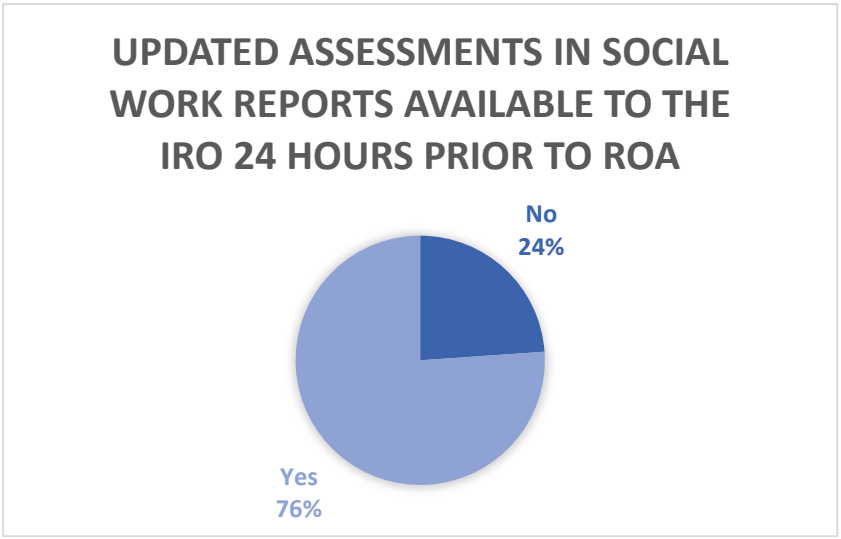
Care or Pathway Plan paperwork available to the IRO 24 hours prior to the ROA:



At the end of 2018/19 the overall percentage of Care or Pathway Plans being available to the IRO 24 hours prior to the ROA meeting stood at 63%. This is a significant increase from the previous year when the end of year average was 47.9%. This improvement is as a result of the implementation of the Quality Assurance alerts where reports had not been received within timescales. This had a significant effect with performance reaching as high as 75.9% in July 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:

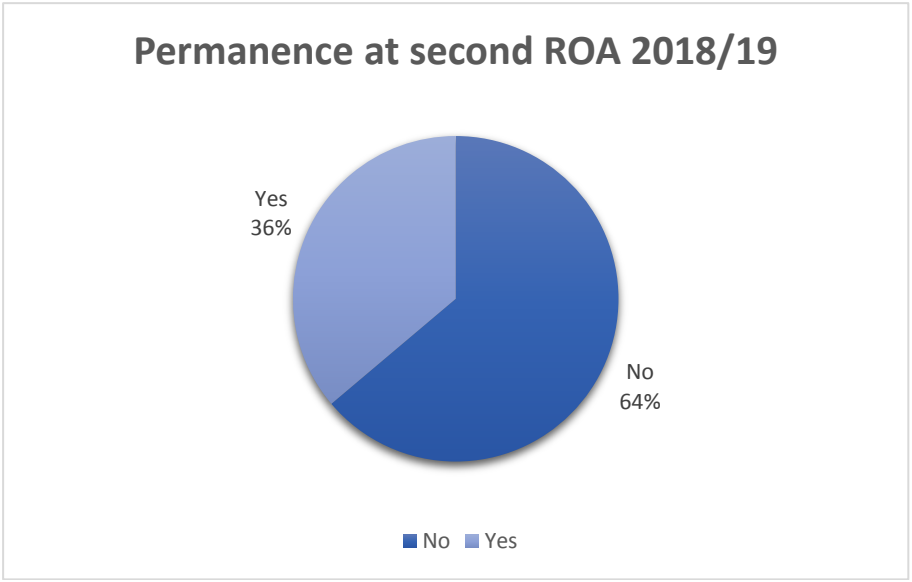


At the end of 2018/19 on average, 76% of Social Work assessment reports were available to the IRO 24 hours prior to the ROA meeting. This is a significant improvement on the previous year which saw an end of year average of 51.1%. Similar to the above statistics, once the IRO service raised the concern and were committed to improving this performance via the Quality Assurance alert process an increase in reports being received in timescale was observed. The IRO service will continue to monitor performance in this area and any concerns will be addressed via the Quality Assurance processes.

Permanence

Securing permanence for children in a timely manner continues to be high on the agenda for IROs and something which is routinely 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.

In between ROA meetings, IROs will also endeavour to track cases and this is recorded on the child's file on Mosaic as IRO case tracking. The IRO footprint has developed significantly during the past three years. IROs are ensuring they have oversight during review periods and addressing any concerns regarding drift and delay. The Safeguarding Unit is looking to develop a template to ensure this oversight is applied in a consistent and unified manner. 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.



Statutory guidance for care planning states that there should be a permanence plan for all looked after children at the time of the second review of arrangements. In 2018/19 the Safeguarding Unit undertook 177 second ROA meetings and of these 64 children and young people had permanence plans agreed at that time. At each review meeting IROs discuss all possible options for a child's permanence and what actions need to be taken for these to be progressed.

One difficulty in this area is the length of time it may take for assessments to be completed on family and other connected carers and in particular delays in identifying those who would like to be considered as connected carers. One means of addressing this difficulty has been for colleague Child Protection Chair's, who may be working with families before the children become looked after, to highlight the importance of Signs of Safety Family Network meetings and what role extended family and friends can play in providing safety for the children. In this way it may be possible that if the child/ children do become looked after there is a strong network of people who understand the issues and concerns within the family and can make an informed decision at the earliest opportunity as to whether they would like to put themselves forward for a viability assessment with a view to offering the children long term care.

As stated above, once these assessments are underway the IRO will track progress of these to ensure there is no drift or delay.

IROs contribute to the Permanence Panel which sits fortnightly. Since the Permanence Panel has been implemented there has 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.

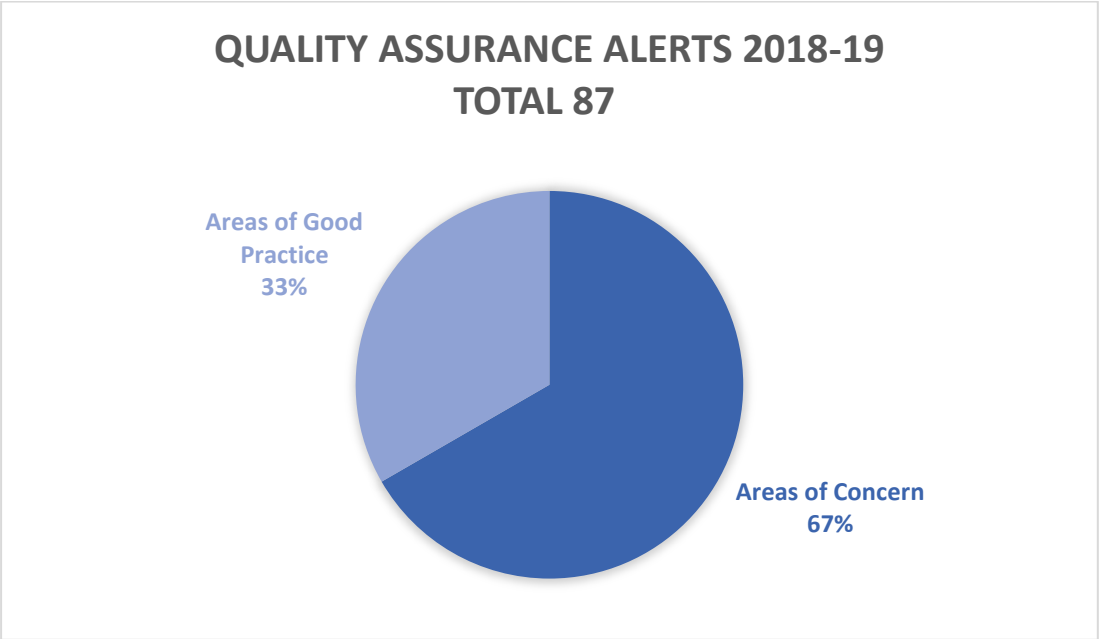
The Permanence Panel makes matching decisions for children requiring long term placements. The local authority is committed to improving the matching processes for children who require long term care and increasing the percentage of children who are in the same placement for two years or more. IROs share their views as part of the reports presented to the panel and make recommendations regarding matches and care plans. It is a significant positive step that IROs are now able to support the decision making for some young people, where appropriate, for their permanence plan to be in a residential placement. At each review IROs will always consider the appropriateness of the child's placement and how best permanence can be achieved, which in many cases will be to move from a residential to a foster placement. However it has now been acknowledged that for some young people a residential setting is far better placed to meet their needs. This is a further indicator of the local authority's commitment to achieve permanence for our looked after children.

IRO Challenge & Escalation

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.

From 1st April 2018 to 31st March 2019 there were 87 Quality Assurance Alerts completed in respect of children in care. Of these there were 29 for good practice and 58 highlighting areas of concern. This is a reduction in the overall number of alerts since the previous year (115), although there was an increase in the number of alerts for good practice from 23 to 29.



18 cases of Excellent Practice have been identified through positive alerts. On a number of occasions this has reflected how impressed IROs have been by the quality of direct work social workers have completed with children. There were also 9 alerts recognising good quality reports and assessments. An example here is the excellent use of Signs of Safety danger statements, safety goals and a child focused safety plan.

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 indicates 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 is recognised that this is an area where we need to continue to develop, and we need to be ensuring that good practice is regularly acknowledged, as this contributes greatly to staff feeling valued and for positive morale within individuals and teams.

In 2018/19, of the 58 Quality Assurance Alerts sent as escalation of concern, the key areas have been in relation to drift and delay within care planning, statutory visits to children not being completed and timeliness of social work reports. The majority of

the Quality Assurance Alerts are resolved in the first stage and do not require further escalation due to the effective response of team managers and social workers and the improved impact for children and families.

As a result of sending the Quality Assurance alert, the IRO requests 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.

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.

IROs ensure that the escalation process for 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. If no response is then 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 will 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 in most cases effective in doing so. However, it is acknowledged that the number of Quality Assurance Alerts, although increasing, is lower than would be expected if the IROs were robustly fulfilling their Quality Assurance role.

An example of a successful Quality Assurance Alert is Child A. Child A was in a placement with connected carers. There had been considerable concern about Child A's emotional well-being due to the impact of trauma during their early life. A course of therapeutic intervention was arranged, and Child A engaged well. At the following ROA all professionals agreed this had been a positive intervention, and it was noted that the therapist recommended an additional twelve sessions to further address the key concerns which had clearly been identified. This was agreed at the ROA and written into the care plan. However, following case tracking the IRO became concerned that there was several months delay in the Local Authority agreeing funding for the additional sessions. Following the alert, the team manager raised this with the service manager and the issues were resolved in a very short space of time. This example highlights how alerts for concern are not necessarily a criticism of individual practitioners or managers but rather, through having a clear escalation process any drift and delay can ensure any blocks or obstacles in the system can be quickly addressed.

In addition to the local authority escalation process, if an IRO has any concerns about a child's care planning, which it is believed cannot be resolved by the internal escalation processes, it is the duty of the IRO to refer the case to CAFCASS. It is however, a procedure which is rarely invoked on a national basis. The Leicestershire IRO service has not referred any cases to CAFCASS in 2018/19.

For the IRO service to be effective it is essential that it retains its independence from the local authority's Children's Social Care Services. The management within the Safeguarding Unit are highly committed to the IROs ability to exercise their independence and ensure that they have ready access to independent legal advice if the IRO wishes to challenge a local authority care plan. In 2018/19 independent legal advice was sought on one occasion. This could be seen as an example of the effectiveness of the escalation process and the commitment within the local authority to resolve issues at the earliest opportunity.

IROs routinely provide a view on care planning as part of the ROA and this is recorded and presented in all cases in proceedings. In addition, the court can ask for a written statement from the IRO; again this is in exceptional cases with IROs only being required to produce written statements on two occasions in 2018/19.

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

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 for Children's Social Care, or if further actions can 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.

Following the Pre-Challenge Tracking Meeting, the managers from the Safeguarding Unit meet with the ADM and Assistant Director monthly to discuss identified areas of concern. Cases discussed in this forum are cases which have followed the full escalation process. Given the quality assurance role of the ADM, particularly in respect of permanence, this working together forum is key to identify themes and areas of practice which need further development.

As an outcome of case discussions held at the Challenge Meeting, a number of cases have been resolved in a timely manner, achieving positive outcomes for children. One example is that of Child B who was residing with his maternal grandmother. Grandmother had stated that she was unable to manage due to her own physical and mental health needs and the level of B's challenging behaviour and complex needs. Therefore, a plan was developed which was to include a residential school placement. This was a highly complicated case in which there had been significant delay and following the escalation process became a subject of the Challenge Meetings. Having reviewed the concerns in some detail the issues were referred the relevant senior manager who ensured this was progressed within a clear timescale and satisfactorily resolved. This has now resulted in B having a suitable residential school place which he enjoys attending during the week and he spends his weekends with his grandmother. There is a robust support package in place including additional respite, provided by the school, when required.

By having clear lines of communication between practitioners and senior managers, working to improve outcomes for children, it has also provided learning opportunities for the practitioners to further develop and improve their practice and care planning.

As part of the Challenge Meeting process managers routinely seek to identify themes which can inform practice that are then disseminated across children's services, for example a recent issue highlighted has been the importance of robust sibling assessments which need to be objective and independent of any other care planning assessments so as not to pre-empt any decision as to what is in the best interests of the children.

More broadly the Safeguarding Unit has undertaken thematic audits as part of the Continuous Improvement Plan. In addition to the service wide audits these are specific pieces of work carried out when issues arise which may need targeted intervention to achieve improvements. One example of this has been looking at the timeliness of pre-birth case conference as it was identified that a significant number of Initial Child Protection Conferences were being held close to the unborn child's estimated due date. It was found that while there were several valid reasons for this, there was sufficient concern to look to develop an action plan which included requiring teams to revisit the relevant LSCB guidance.

Children and Family Court Advisory and Support Service (CAFCASS)

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.

The Safeguarding Managers attend management meetings with CAFCASS Service Managers along with colleague Service Managers from Children and Family Services and Legal Advisors from both Leicestershire and Leicester City to discuss areas of mutual interest and concern. It is positive that CAFCASS management has expressed a strong commitment to continuing to build productive working relationships between IROs and Guardians. Through Guardian's attendance at ROAs and planned joint IRO/Guardian workshops they are developing a shared understanding of the child's needs and good communication to achieve outcomes in the best interests of children.

Family Justice Board

The Safeguarding and Improvement Unit 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

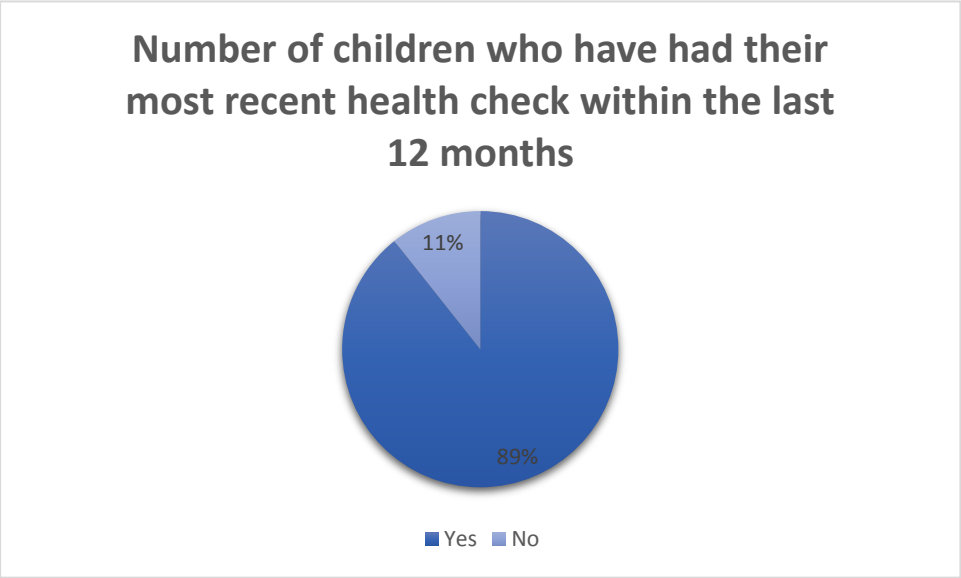
The IRO Service has continued to engage in the East Midlands Regional IRO forums and has had the benefit of four tailored training and networking opportunities over 2018-19 covering several areas to support professional development, including quality assurance. As a result of the quality assurance day in February 2019 the Safeguarding Unit has undertaken to develop a standardised template for IROs to complete mid-way desktop case reviews to ensure care planning remains on track, as well as developing a consistent approach to the quality assurance of plans, 28 day ROAs and subsequent reviews.

Personal Education Plans

In 2018/19 eighty-five per cent of all looked after children had a Personal Education Plan (PEP), this is in line with the previous year. At ROA meetings IROs routinely confirm if PEP meetings have taken place, that all recommendations are being progressed and if this is sufficient or whether further actions necessary. Completion of PEP's is seen as high priority as they are fundamental to ensuring each child has access to the right educational support to enable them to achieve their potential. To this end IROs work closely with the Virtual School, with the Education Improvement Officers regularly attending the child's ROA.

There are several reasons why a child may not have a PEP on file, one of the most significant being that they are not in school due to an unplanned placement move. With any unplanned move the IRO will undertake a 28-day ROA to ensure the right steps have been taken to support the child in their new placement, including education provision. This has been an area of increased focus within the Safeguarding Unit in 2018/19, to ensure there is no drift and Safeguarding Managers have been reviewing caseloads with IROs in supervision to identify any cases of ongoing concern where a young person is not accessing education and requires escalation within the Education Department through the Virtual School.

Health Checks completed within twelve months



In 2018/19, of the 599 children who were eligible for a looked after health assessment, 89% (535) children had one completed. The number of children who have had their health review completed on time has increased from 79.6% in 2017/18 to 82.2% in 2018/19.

Again, this has been a key focus within the local authority with the importance of these being raised across a range of forums including the Corporate Parenting Board. Within this reporting period the Service Manager for the Safeguarding Unit along with the Looked After Children's Nurse from the Clinical Commissioning Group have undertaken an improvement activity audit to assess the effectiveness of IRO challenge within the ROA process. The focus of this has been to ensure both Initial Health Assessments and Review Health Assessments are completed on time and that the contents of the assessments are informing care plans.

The audits found some strong examples of good practice, such as the health needs of the child being clearly documented in child friendly language as well as appropriate challenge of drift. However, it was identified that this good practice needed to be more uniformly embedded within the ROAs. A number of improvements were outlined including the need for more consistency in IROs ensuring all health needs are highlighted and the need to have oversight of the health care plan and actions to ensure that these are being progressed without delay.

It was also highlighted that the Strengths and Difficulties questionnaire, which looks at the child's emotional health and wellbeing, should be a more integral part of the ROA process. A comprehensive action plan was developed and implemented in the final quarter of 2018/19, therefore impact of this will be documented in the 2019/2020 report.

Dental checks within a twelve-month period

As with health reviews dental checks are viewed with high importance in contributing to children and young people's wellbeing. In 2018/19 out of 599 children, 465 (77.6%) had a dental check within the last twelve months. Again, this is an area which is routinely scrutinised by IROs within the ROAs. The general expectation is that all children in care see the dentist every six months.

Independent Reviewing Officer: Child Protection Chair

Child Protection Conference Activity

The number of Initial and Review Child Protection Conferences chaired over 2018/19 was 851, involving 1,565 children.

Children discussed at ICPC

	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Child to be Subject of CP plan	35 97.2%	39 95.1%	27 100.0%	32 97.0%	36 87.8%	37 97.4%	42 91.3%	48 78.7%	52 92.9%	41 95.3%	45 88.2%
No CP Plan required	1 2.8%	2 4.9%		1 3.0%	5 12.2%	1 2.6%	4 8.7%	13 21.3%	4 7.1%	2 4.7%	6 11.8%
Grand Total	36 100.0%	41 100.0%	27 100.0%	33 100.0%	41 100.0%	38 100.0%	46 100.0%	61 100.0%	56 100.0%	43 100.0%	51 100.0%

Children discussed at ICPC per month

In 2018/19 there were 516 Initial Child Protection Conferences (ICPC's) of which 42 (8%) had an outcome of no Child Protection Planning. This small number of children not being made subject to a Child Protection plan at ICPC indicates that consistent and appropriate thresholds are being applied in relation to children being at risk of significant harm. This results in the right children being considered in need of child protection planning and therefore receiving the right support at the right time.

Numbers of Child Protection Plans

Numbers of children subject to child protection plans measured at year end (31st March 2019) has slightly decreased from the previous reporting year:

2017-18	394
2018-19	388

Repeat Child Protection Plans

In this reporting period the rate of children becoming subject to a child protection plans for the second or subsequent time has again reduced to 15.2%.

Repeat planning analysis has continued to be common practice for the Conference Chairs, who are required to complete their analysis as part of their preparation for the Child Protection Conference.

IROs are independent of the care planning process and a primary focus of an IRO is quality assurance. This enables IROs to be in a prime position to highlight and analyse concerns that have led to further child protection planning. This analysis and understanding will assist the IRO in setting out a robust plan with clear timescales to ensure that the needs of children and families are understood and comprehensively responded to, to prevent drift and delay or lack of progress for the family.

Repeat child protection plan figures 2018/19	**%**
Leicestershire	15.2%
Statistical neighbours	21.8%
East Midlands	20.5%
National	20.2%

As part of the Quality Assurance learning framework, two audits of repeat plans have been completed in 2018/19 by the managers of the Safeguarding and Performance Service covering August – November and December- February.

The range of time from the previous plan to the current plan ranged from 8-80 months, with the majority of cases being over 18 months. The low number of repeat planning and the timeframe for the subsequent conference is positive, as it highlights a low rate of children being considered at risk of significant harm for a second or subsequent time. This suggests that the right decision was made and support was in place at the end of the previous plan.

The audit work also highlighted that there had been drift and delay in some cases and elements of a ‘stop start’ process for children and families through changes in social worker. The impact of this is significant for children and families as it can impact on the continuity and robustness of the child protection plan and the safety plans with families. The changes achieved by families may not then be sustained, resulting in services having to become involved again.

The majority of the identified cases where there had been previous Child Protection planning were stepped down to Child in Need plans, as opposed to ending involvement of children’s social care. Those that had closed, did so due to sufficient safety being identified within the family and in cases where Court Orders were in place.
Neglect was a clear dominating risk category in 16 of the 21 cases audited. The trilogy of risk was also a common theme and professional optimism was highlighted as an issue in a few of the cases, especially in relation to domestic abuse. One of the key actions from the audits is for the IRO to ensure that there is evidence of appropriate assessments and intervention that is having a positive impact on the outcomes for children and families. For cases stepping down to a Child in Need plan, the IRO has a pivotal role in facilitating the discussion to ensure plans are robust, generated by the family and that their network and professionals continue to engage with the family.

The performance data shows Leicestershire’s maintained reduction of repeat planning and this highlights that the best practice indicators above are successfully

being implemented in the majority of cases where child protection plans are being ended. The impact for children and families is that they are provided with the best opportunities to successfully maintain safe and good enough family environments where children are not at risk of significant harm.

Plans Ending

Over 2018/19 the performance data showed that of the 505 Child Protection plans ending in the reporting period, 73 (14.4%) ended at the first Child Protection Conference. This remains a low figure, which again indicates that the reason for the ICPC was right, and in the majority of cases there was a safe rationale for ending the Child Protection Plan. This was 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. There is now an extra element of oversight in these cases that includes the need for agreement from the Service Manager for a child protection plan to end at the first Review Child Protection Conference.

Length of Plans

Plans that have been in place for lengthy periods of time are also scrutinised to look at the effectiveness of the intervention and how robust the approach is in bringing about lasting change/permanence for children and young people.

Over this reporting period there have been two audits to look at the cases subject to a child protection plan over 18 months. The audits covered August - February and moving forward will be completed every four months by the Safeguarding Managers. The audit highlighted inconsistency in quality assurance alerts being sent by IROs in relation to drift and delay in cases and the limited IRO footprint on these cases. As a result of this audit more robust monitoring is now in place that includes conference chair oversight by the second review of all child protection conferences to ensure the plan is not static or not providing safety for the child/ren. This is to ensure that plans are robust and impacting positively on the outcome for children and families and if not, then the role of the IRO as a critical friend is to highlight the issue and provide support to drive the plan forward in the best interests of the children.

The audit also showed that the highest risk category for children subject to plans over 18 months is neglect and that the use of the neglect toolkit to support with understanding of the issues and measurement of change had not been consistently used with families. Further work has been done with IROs and locality social work teams to re-invigorate the use of the neglect toolkit to ensure children and families are given the tools and best opportunity to affect positive change.

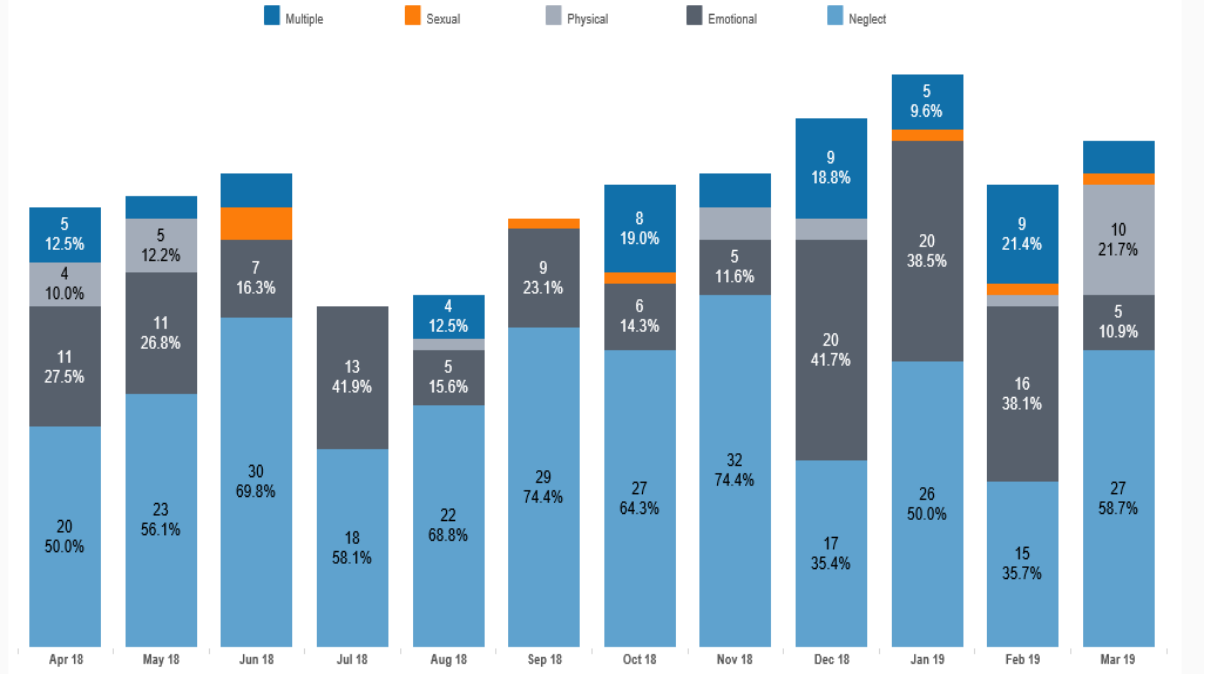
Child Protection Plan Categories of Risk

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; neglect, emotional abuse, physical abuse and sexual abuse. In 2018-2019 the breakdown of categories of abuse at the start of the child protection planning for the 499 children

whose Child Protection Planning started was Neglect 286 (57.3%), Emotional 128 (25.6 %), Physical 26 (5.2%), multiple 51 (10.2%) and Sexual 8 (1.7%).

These figures are very similar to the previous reporting period, the only slight difference is that the risk category 'Physical' is slightly down from 11% to 5.2% and that the multiple category has increased from 7% to 10%.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Grand Total
Neglect	20	23	30	18	22	29	27	32	17	26	15	27	286
Emotional	11	11	7	13	5	9	6	5	20	20	16	5	128
Physical	4	5			1			3	2		1	10	26
Sexual			3			1	1			1	1	1	8
Multiple	5	2	3		4		8	3	9	5	9	3	51
Grand Total	40	41	43	31	32	39	42	43	48	52	42	46	499



This data continues to highlight that neglect is the primary risk category. During this reporting period there has been a Neglect Thematic Audit completed and the findings highlighted a lack of consistent use of the neglect tool kit; a finding also in the repeat planning audit discussed previously within this report. This audit highlighted that, of the cases where the neglect tool kit had been used, this supported the analysis and had been used to inform the child's plan. There has been a co-ordinated response from both from the IRO service and Quality Assurance team to re-engage the use of the neglect tool kit as it has a clear positive impact on assessment, analysis and plans and therefore the outcome for children and families.

Children subject to a plan under the category 'at risk of sexual abuse' continues to be low at 3.7% (children subject to a plan under the category of sexual abuse including both singular and multiple categories). Whilst nationally the prevalence of children subject to a child protection plan by initial category of sexual abuse has reduced since 2015, with the rate dropping from 4.7% in 2015 to 4.1% in 2018, reporting in Leicestershire is lower than this level. In response to this under

representation there has been a specific piece of audit work undertaken within this reporting period that looked at the number of cases that have a 'risk of sexual abuse' identified from the point of contact to those subject to a child protection plan under this category.

The analysis of this audit did not highlight a concern regarding the response, assessment and outcome for cases where sexual abuse had been identified as a risk factor from the point of contact. Child protection plans, with the category of sexual abuse, which had ended did not identify an issue with plans ending too early and all had appropriate decisions for the family. None of the cases that had ended had re-referrals. A recommendation of the audit for the IROs was for a stronger analysis regarding decision making around the category used and for this to be clear where the category of the plan changes. These recommendations have been taken forward with IRO team.

The IROs have continued to address and be mindful of having multiple categories of risk used in Child Protection plans, although there has been a slight increase in the use of multiple categories from 41 (2017-18) to 51 (2018-19). Ensuring that multiple categories are used appropriately and only when required remains a focus of the Safeguarding and Performance Service. The use of multiple categories can impact the identification of need from a departmental commissioning perspective and more importantly can make it less clear for children and families as to the primary presenting concerns.

Following learning from a serious case review a case file check of cases which have used the 'emotional abuse' category in either the last six months or last 20 cases was undertaken This was to establish if 'emotional abuse' was being used as the appropriate category within those cases. The report author agreed with nineteen out of twenty cases that Emotional Harm was an appropriate category, although in several cases there was justification for dual categorisation.

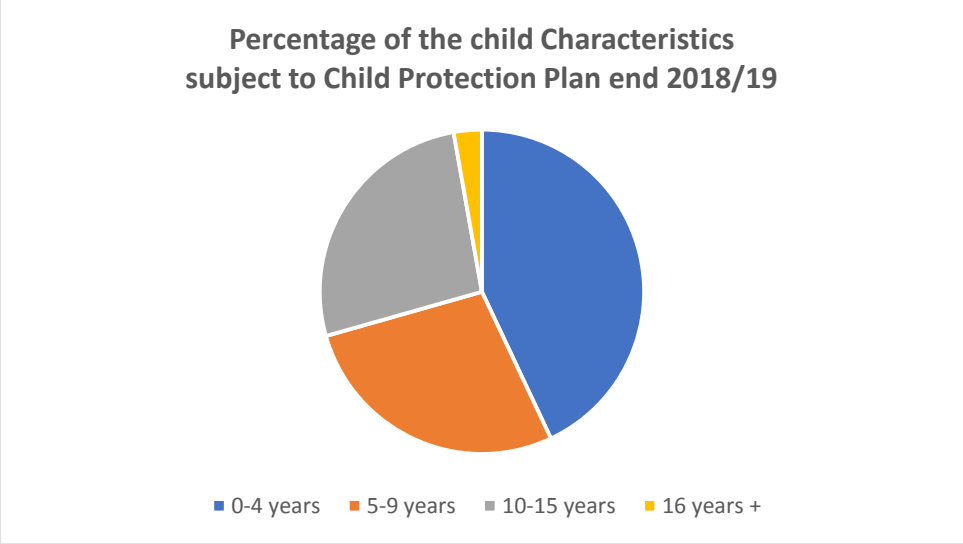
Following the audit there has been work undertaken with the IROs to have a collective understanding of when dual categories are appropriate and in what circumstances the category of 'physical abuse' should take priority over the category of 'emotional abuse'. Consideration will be given to all risks but dual categories should be reserved for when there is equal concern in two areas. Ensuring the right category is used is central to developing a robust and effective plan to achieve positive change and outcomes for children and families.

Child Characteristics

The age range of children subject to a Child Protection Plan remains similar to the previous reporting year:-

Age	**Percentage of the child Characteristics subject to Child Protection Plan end**	
	2017/18	**2018/19**
0-4 years	40.5%	43%
5-9 years	30.5%	27.6%

10-15 years	25%	26.6%
16+ years	4%	2.8%



The gender of children subject to Child Protection Plans for this reporting period remains the same - Female 49% and Male 51%.

The ethnic profile of children subject to Child Protection plans also remains 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.

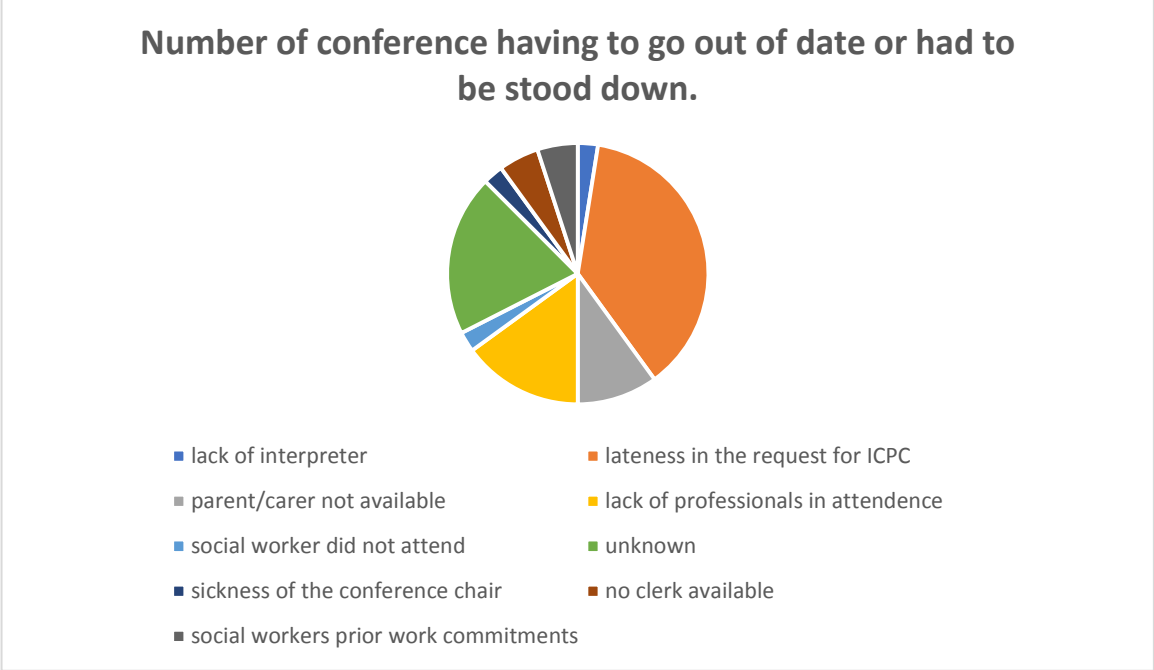
Historically the data in Leicestershire regarding numbers of children with a disability subject to a Child Protection Plan is low although there continues to be no accurate way of collecting this data.

Conference Performance

For the reporting period 2018/19, there were 851 Child Protection Conferences and 40 (4.7%) had been problematic from the perspective of having to go out of date or be stood down on the day and rearranged; this is a slight increase from the last reporting period which stood at 2.5%. Although this is a very small percentage, the impact for all concerned, especially the families, is acknowledged. When this happens, any learning is considered, and avoidable issues are taken up by the Service; for example delay in social worker requesting the conference is addressed with their line manager, agency attendance is taken up with agency leads and Quality Assurance Alerts are considered.

The main reasons for conferences not being able to go ahead at the time are recorded in the table below;

Number of conference having to go out of date or had to be stood down.	Reason.
1	Lack of an interpreter
15	Lateness in the request for an ICPC
4	Parent/carer not available.
6	Lack of professionals in attendance
1	Social Worker did not attend conference.
8	Unknown reason
1	Sickness with the Conference chair
2	No clerk available
2	Social Workers work commitments.



The timeliness of Review Conferences over this reporting period was good with 97.3% convened within statutory requirements, which is a very similar figure to the last reporting period at 97.1%. Timeliness of Initial Child Protection Conferences remains consistently high at 91.5%. The table above highlights the many challenges to convening conferences in a timely manner. The achievement in maintaining good performance data in timeliness indicates the dedication and understanding of the importance for children and families to respond with the right action at the right time and minimise delay.

There has been an increase in conferences being stood down due to the lack of professionals in attendance from 3 in the last reporting period to 6 in this reporting period. Work is being undertaken in collaboration with the Local Safeguarding Children Board (LSCB) to improve attendance and engagement of partners at conference to ensure that the issue of quoracy is minimised and that the child

protection conference is meaningful and effective for the engagement with children and families.

Conference Records

Distribution of child protection conference records during this period continues to be very timely, largely because of a collaborative approach with the team that provides administrative support for conferences.

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. 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.

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 staff are referenced and considered in more detail within this report.

The service strives to provide the same conference chair for all conferences for a family, but this has continued to be a challenge over this reporting period and has not always been achieved due to recruitment and 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 overall, the additional capacity of 2 FTE IROs agreed 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 prepared and are in the best position to provide a good service.

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.

During this reporting period there has been continued consideration to ending the child protection planning for looked after children to prevent dual planning for children and young people once they have been accommodated into local authority care. Currently 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. Since the reporting period there has been agreement to a process and guidance to enable ending of a child protection conference by letter at the 28 day Review of Arrangements meeting.

Social Work Conference Reports

In line with LSCB procedures and the Practice standards, parents should receive the report for an Initial Conference at least 1 working day in advance of the conference 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 of the Review Child Protection Conference.

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.

Performance in this area has continued to evidence improvement; 75% of parents received the report before conference (69% last year), 22% on the day of the conference and 3% did not receive a report at all. There is still room for further improvement and work continues to take place to ensure all parents receive the report within the expected timescales.

Consultation

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

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.

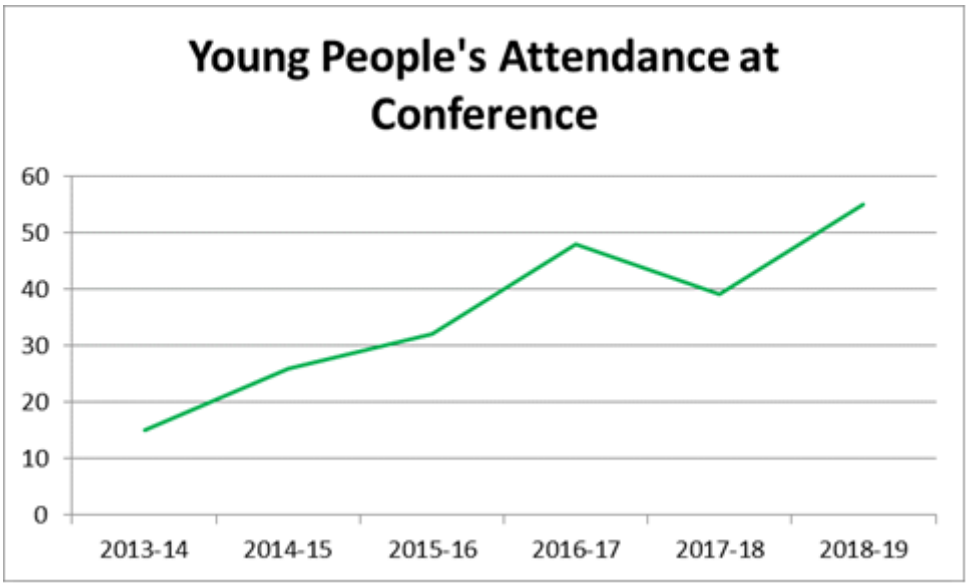
It is unfortunate that over this reporting period agency participation is not fully recorded for the whole year as the recording is incomplete. The LSCB has convened a task and finish group to look at professional's attendance at conferences and make recommendations for improvement. There will also be a full 12 months report for attendance for 2019/20.

Implementation of Signs of Safety Child Protection Conferences

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 and Performance Managers which 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.

One of the four behaviours that underpins Leicestershire's continuous improvement plan, "The Road to Excellence" is the importance of voice 'listening and responding to what the child and family tell us'. Within child protection conferences, the implementation of the strength based Signs of Safety framework ensures a collaborative approach with families and recognises the importance of their voice being key to decisions. We have a comprehensive advocacy offer for children (10+years) attending child protection conferences through our Children's Rights Service (CRS), which ensures that they are supported to attend if this is what they want to do, or their views are represented if they do not.

The majority of children and young people choose not to attend their conference. Nevertheless, during the year there were 55 attendances of young people at their conferences which is an increase from 2017-18 and represents the highest figures since the CRS began supporting young people through the CP process.



Leicestershire County Council

Young person: R, 17 years, subject to a Child Protection Plan ***Case Summary:*** R had been on a CPP for almost 2 years and was approaching her 18th birthday. Parents would not engage with CFS and were refusing to allow R to see any social workers alone which left her at risk. R was NEET, but wanted to be in education, this meant she was very isolated.		
The worries	***What worked well***	***Outcome for young person***
• R was not in any form of education, employment or training and had not been for over 3 years. She spent the vast majority of her time at home, under the supervision of her parents. • R had a Risk Assessment from CAMHS which meant that colleges felt unable to offer R a place without additional support. However, R did not have an EHCP to enable additional support to be put in place. • R had had 3 changes in social worker for the duration of her Child Protection Plan. • R's parents prevented workers from speaking to R alone, were dishonest and prevented R from accessing tuition which was put in place by CFS.	• R engaged well with the CRO, CRO was able to insist that parents allowed her to see R alone in order to be able to carry out effective advocacy. R's strong views about this reinforced this position. • The CRO was able to represent R with the Special Educational Needs service and to parents. CRO was able to facilitate a meeting between R and the Educational Psychologist, which parents tried to prevent. • CRO was able to facilitate a meeting between the Transitions Social Worker, college and R (at R's request) so that they were informed about R's concerns re. her parents and she was reassured that they would work with her, in her own right, given her age and clear views.	• R received an EHCP quickly and was accepted onto her chosen college course. R was achieving well and had safety people she could speak to at college, so she was not so isolated. • As R had an EHCP she was eligible for a Transitions social worker who worked well with R, and ensured an Adult Mental Health social worker was in place prior to R turning 18. This ensured R had ongoing support and safety in place. • R became more confident to speak to other professionals over the time the CRO was working with her, partly because she felt supported to give her views. ***Increased safety*** ***Improved school attendance/attainment*** ***Increased YP Voice***

For those younger children who do not have the offer of advocacy the IRO (conference chair) will ensure that the voice of children is central to the child protection conference and the paperwork brought to conference supports the requirement for this to be captured and shared.

Completing the child protection conferences using the Signs of Safety framework ensures that the conference process is inclusive of the family and is completed with them. The impact for children and families is that they understand the worries and risks and feel valued and included to work towards achieving and maintaining change. It is evidenced that good relationship-based practice will improve outcomes for children and families.

There continues to be improving evidence of good quality child protection plans that were SMART (Specific, Measurable, Achievable, Realistic, Timely). However this is not consistently the case across all plans. The goal is for all plans to be outcome focussed and owned by the family. The main challenge has been to ensure that all child protection plans identified clear bottom lines and Safety Goals for the family and that all plans set out clear outcome focused objectives with timescales.

The discussion around these issues formed part of the work with IROs in the Signs of Safety Development Day highlighting their Quality Assurance role to be the critical friend and to support improved practice and outcomes. It was also acknowledged that the outline child protection plan created by the IRO at the end of a child protection conference needs to support the development of a SMART plan. In addition, IROs have observed and shared each other's practice, as part of their peer reviews to support learning from good practice. This will continue to be supported moving into the next reporting period.

Feedback

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 Worker's and Team Manager's in supporting case discussions and skilfully managing the Child Protection Conferences.

We have gathered feedback from families and professionals on their child protection conference experience; in the main there was good feedback and most people felt that their conference experience was positive in the fact they felt they were able to contribute.

Below are some of the comments made.

- The meeting was chaired well.
- The meeting was very child focussed.
- One parent would have benefitted from seeing the social worker's report prior to the conference.

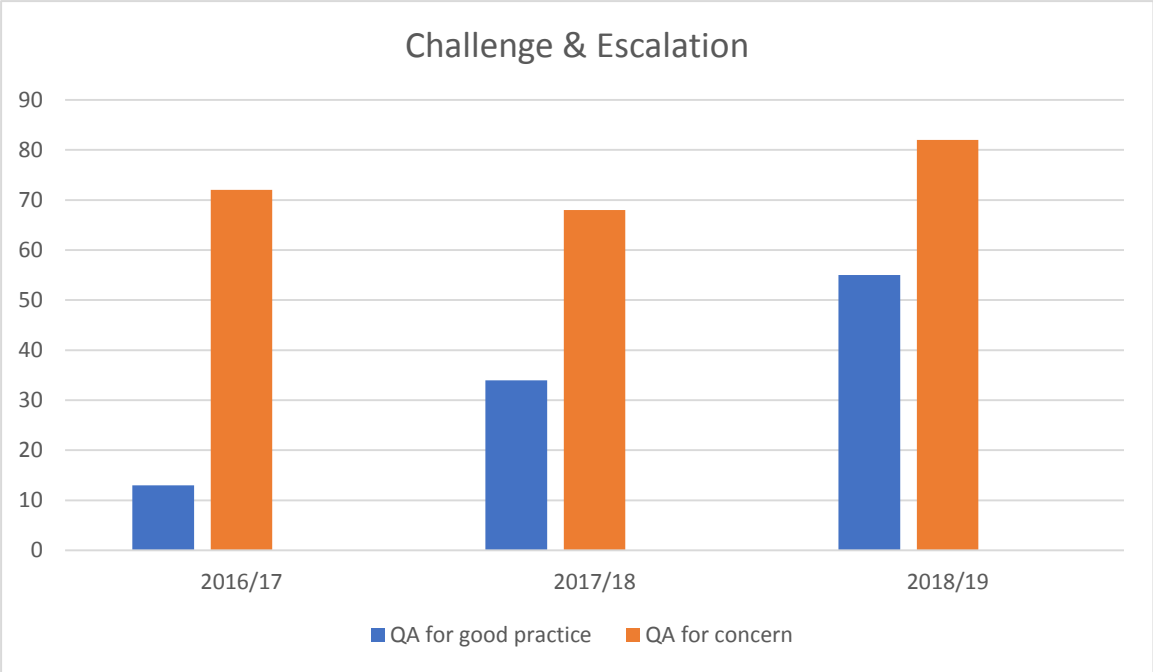
Challenges & Escalation

As referenced in the introduction of this report, IROs within the Safeguarding and Performance Service 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. This ensures there is a clear and consistent process that can be reported on and provides 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 as well.

For this reporting period 2018/19, there were 137 IRO Quality Assurance Alerts. 55 of these were good practice alerts raised and 82 were alerts for concern. The amount of IRO Quality Assurance Alerts has increased steadily from 2016/17.

However, it is acknowledged that the number of Quality Assurance Alerts although increasing is lower than would be expected with IROs robustly fulfilling their Quality Assurance role and supporting improvement in practice and impact for children and families.

Monthly overview reports are completed and shared with departmental senior management meetings (SMT) and fed into performance meetings.



Good practice examples have noted:

- Great report from the Social Worker and excellent presentation at conference and great contributions/suggestion to CP Plan. Thorough piece of work.
- Workers have worked hard to ensure the best outcome for a new born baby, particularly working across borders, distances involved, and varying process and procedure and risks involved, social work team did not transfer to a longer-term team due to this transferring to another local authority.
- Social worker attending social events out of her normal working hours in support of children in care and celebrating their successes.
- Excellent matching and transition plan devised for two children in care and supporting them through their move of placement.
- Progress of the child protection plan was thorough and timely.
- Social worker has a great relationship with the young person she is working with and has always promoted her aspirations; encouraging her but also giving her practical and realistic advice and support and has always been open and honest with her. Clear plans are in place for her prior to and post turning 18, the social worker has worked hard to ensure this young person has had as many opportunities as possible.

Concerns:

The key areas of concern in this reporting period was drift and delay and statutory visits to children not being completed in line with statutory timeframe or as agreed in plan.

Timescales:

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.

Over this reporting period safeguarding managers have been discussing Quality Assurance within supervision along with cases that may need to be escalated to the Pre-Challenge/Challenge meetings. The Service Manager for Safeguarding and Performance also attends the Service Manager meetings for field work. This is to support with shared peer challenge and learning from themes highlighted through Quality Assurance Alerts.

Appeals/Complaints

Children continued to be offered to be supported in attending or having their voice heard in child protection conferences. There has not been any young person who has appealed the decision to make them subject of a child protection plans in this reporting period. They are supported by the Children's Rights Officers, for which there is a separate Annual report giving more detail around children's participation and voice in child protection conferences.

There have been thirteen complaints made by parents/carers in this reporting period, most of which were a joint response between the safeguarding and performance unit and the identified locality team. Most were resolved at Stage 1, and on one occasion the service manager and Head of service went to meet a family. There is one complaint that has gone to stage 2, with regard to the reporting period and this was still ongoing.

Harmful Sexual Behaviour

This has been a very busy and exciting period due to the implementation of Harmful Sexual Behaviour (HSB) processes and procedures across Children & Family Service. This has heightened the profile of HSB and raised the awareness of the support needed for these young people and their families through the roll out of the new HSB Policy and the new HSB meetings which are convened by trained IROs.

The Safeguarding Lead has continued to be involved in a significant amount of development work that has been undertaken across CFS and has attended regional HSB meetings every quarter.

A task and finish group was established to develop the operational response to HSB, made up of key managers and practitioners from CFS including the HSB lead, specialist therapeutic social worker, along with Police Child Abuse and Investigation Unit and Learning and Development representatives. Through these meetings the HSB procedures, policies and tools are now readily available on the intranet and through the learning hub.

There has been an increase in training throughout CFS for staff at all levels in the assessment and referral for children and young people exhibiting HSB.

LCC in the context of National Developments

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 about 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

Staff understanding of HSB thresholds has continued to improve over this reporting period. There continue to be different levels of training needs across the staff group; 'Brook's traffic light tool' basic training for all CFS staff, AIMS 3 training for experienced qualified Social Workers, AIMS training for managers supervising cases of HSB and 'good lives intervention model' for those practitioners who have completed the AIMS 2/3.

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.

AIMS 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 2017/18 there are over 60 Social Workers whom are AIMS 2 trained, we now have 3 IROs trained in AIMS 2 and the Safeguarding Manager is also training in AIMS 2.

AIMS 3 will be available in the summer 2019 and this training will be made available for staff across CFS. The main differences between AIMS 2 and AIMS 3 is that it considers technology assisted HSB and can be completed with younger children. Managers from the teams, where staff members have completed the AIMS 2 training, should be giving these workers permission to use this qualification and work alongside the allocated social worker in completing this risk assessment.

AIMS training for Managers is designed to support line managers who supervise workers undertaking the AIMS 2 and intervention programmes with children and young people who display HSB.

Harmful Sexual Behaviour Meetings

Historically HSB meetings have been in the main one-off meetings. The ambition is for there to be a full review of the HSB for each identified young person, where an initial HSB meeting was convened and if adopted then a safety plan can be put into place along with an action plan. This action plan is then reviewed until the group of professionals and family agree that the plan is as safe as it can be and that the family and professionals own this plan and adapt it accordingly for the HSB meetings to come to an end. This process focusses upon the needs, risk and safety of the child(ren) and provides a framework where plans can be reviewed, amended and updated to ensure that the needs of the child are being met.

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.

Recommendations 2019-2020

1. Following the increased capacity within the IRO service and the safeguarding administration team, improvement in the timeliness of production and distribution of LAC Review records needs to be evidenced. Managers will have robust oversight of records timeliness and caseload analysis within the team to ensure that senior managers are aware of pressure points within the year. There has been the introduction of Actions from Review of Arrangements being uploaded within 5 days. In addition, IROs are also uploading their own records so we will be able to report on both areas in 2019/20 which will give a more accurate picture both IRO and administration team improvements.

2. Development of a broad use of tools to support the participation of children in their Review of Arrangement. Consideration of the use of technology to support inclusion. In addition to continue to build upon ensuring that LAC Reviews are more child focused and to develop our opportunities for gaining feedback to inform our learning cycle.

3. Operational teams to evidence improved and sustained performance over 2019-20 in relation to timeliness/availability and quality of social work reports, updating assessments and plans for LAC Reviews and child protection conferences. This will be achieved through effective use of the Quality Assurance Alert to highlight poor practice and celebrate improvements in terms of timeliness and engagement of children and families.

4. Improvements in how the LAC review effectively supports good emotional and physical health for children in care. For the review to consider the health action plan from the initial/review health assessment. For the IRO to have an

understanding of the Strength and Difficulties Questionnaire score to develop the care plan and to ensure that the leaving care health summary is understood and engaged with by young people and carers.

5. Development of the Quality Assurance Alert process on Mosaic to enable better performance data to be captured to ensure the alert process being central to the learning cycle. 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. IRO Service to provide quarterly IRO QA Alert overview reports to SMT and Performance Meetings.

6. IRO Service to work closely with CAFCASS over 2019-20 to ensure full and consistent application of the IRO/CAFCASS Protocol – particular emphasis on improving the instances of formal handover from the Children's Guardian to the IRO at the conclusion of proceedings and participation of Children's Guardians in LAC Reviews.

7. 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 through quarterly audit by Safeguarding Managers.

8. IRO Service to consistently implement the process to systematically review cases of children subject to CP plan for 9 months and consider exit plans that will achieve maintained safety and permanence for children

9. IRO Service to maintain good performance in relation to timeliness of both initial and review child protection conferences.

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

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

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