Report to:	Overview and Scrutiny Committee (Children's Services and Safeguarding)	Date of Meeting:	30 th January 2024	
Subject:	Quality Assurance and Practice Improvement			
Report of:	Assistant Director of Children's Services (Quality Assurance and Safeguarding)	Wards Affected:	(All Wards);	
Portfolio:	Children's Social Car	Children's Social Care		
Is this a Key Decision:	No	Included in Forward Plan:	No	
Exempt / Confidential Report:	No			

Summary:

This report will provide an overview of Quality Assurance and Practice Improvement activity during October and November 2023, in Sefton Children's Social Care. In addition to this it will set out the findings from audits over the last 12 months, enabling a view of direction of travel and areas of focus. Alongside the 'deep dive' audit activity which takes place each month, an increasing amount of focused dip sampling and quality assurance is now taking place. This work is undertaken as a result of lines of enquiry opened by performance data, or the need to evaluate or understand a discreet area of practice. There is a clear need to balance the resource available for quality assurance that provides a line of sight on practice with improving practice and working alongside operational colleagues.

Recommendation(s):

To note the contents of the report

Reasons for the Recommendation(s):

To provide Members with an overview of Quality Assurance and Practice Improvement activity during October and November 2023.

Alternative Options Considered and Rejected: (including any Risk Implications) N/A

What will it cost and how will it be financed?

- (A) Revenue Costs N/A
- (B) Capital Costs N/A

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):	
N/A	
Legal Implications:	
N/A	
Equality Implications:	
There are no equality implications.	
Impact on Children and Young People:	
NO	
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Climate Emergency Implications:	
The recommendations within this report will	
The recommendations within this report will	I NO
Have a positive impact	NO
Have a neutral impact	NO
Have a negative impact	NO
The Author has undertaken the Climate Emergency training for	YES
report authors	

Contribution to the Council's Core Purpose:

This work is undertaken as a result of lines of enquiry opened by performance data, or the need to evaluate or understand a discreet area of practice.

N/A		
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What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.7505/24....) and the Chief Legal and Democratic Officer (LD.5605/24....) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

N/A

Implementation Date for the Decision

Immediately following the Committee meeting.

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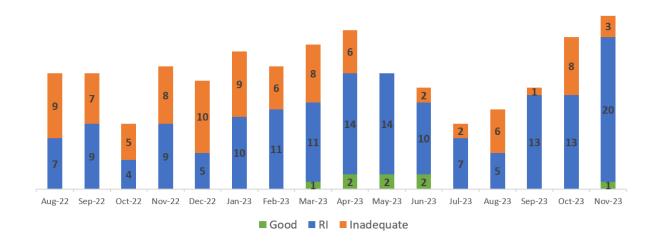
Appendices:

N/A

Background Papers:

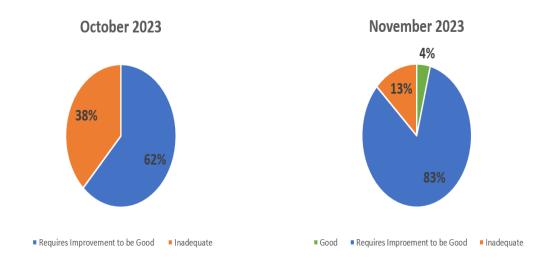
1. Audit judgements - last 12 Months

The chart below summarises activity over the last 12 months; it provides a wider context and shows gradual improvement overtime. There is clear evidence that the amount of work graded Inadequate has reduced significantly over the last year; (December 2022 66% versus November 2023 13%). Good work has been identified but this is not consistent each month. Most work audited is considered Requires Improvement to Be Good.



2. Recent Audit Activity - October and November 2023

Since the last report, **45** deep dive audits have been completed across Childrens Social Care (October and November 2023). **21** of these audits were moderated **(47%)**.



24 audits were completed during December 2023 which will be analysed and commented upon along with January audits in the next report. A verbal update for December 2023 will be available for the Improvement Board in January 2024.

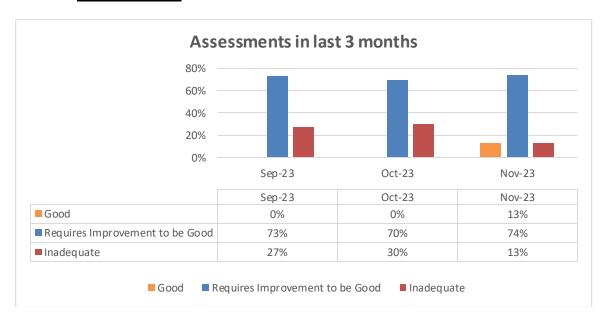
3. Audit Findings linked to Sefton 5 Practice Priorities:

Sefton's improvement plan identifies 5 'practice principles' which will be our focus moving forward, these are:

- Assessment
- Plans and Planning
- Child centred
- Management Oversight and Supervision
- Creating Permanence

To align with this latest version of the improvement plan, quality assurance will focus more specifically on these principles and their role in achieving good outcomes for children and their families.

3.1 Assessment



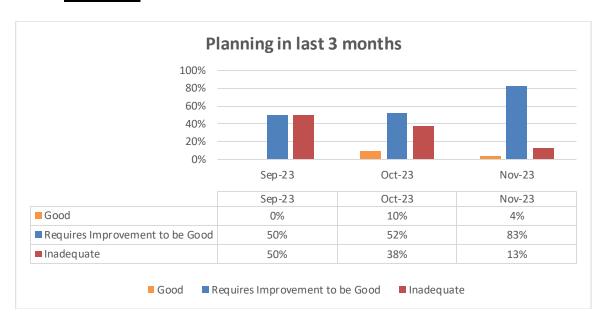
What do we know?

- Positively, most assessments are undertaken in timescale and demonstrate an understanding of the child and family's needs.
- Direction of travel above indicates measured improvement.
- Weaker assessments often lack depth and do not consider family history and capacity to change.
- Assessments can focus on singles issues, rather than explore the wider picture.
- When sexual abuse is recognised as a potential risk, there is limited exploration of this/direct work completed to understand and inform the assessment.
- Little or no information recorded on fathers; meaning disproportionate number of actions/ responsibilities assigned to mothers – missing information and or opportunities.
- Updated assessments following significant events or changes in circumstances are not consistently being completed; meaning information is lacking in terms of the child's current needs.
- There needs to be increased evidence of effective analysis which then goes on to form the 'bridge' to creating smarter plans that can make a difference.

3.2 Impact of any improvement or learning activity

- Good assessment training has been created and rolled out to relevant teams between August – December 2023. Comparing grades for domain area linked to assessment; improvement is evident.
- As more assessments are completed, the impact of this training should evidence continued improvement, this will be monitored through ongoing quality assurance.

4. Planning



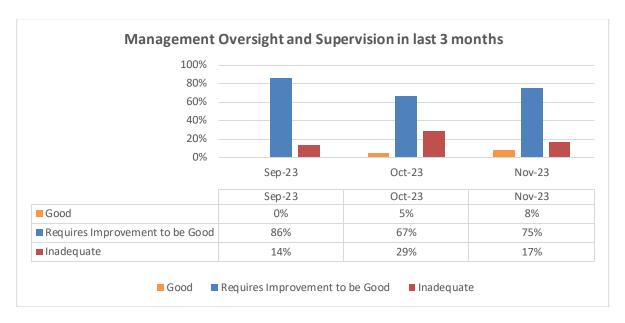
4.1 What do we know?

- Positively, parents and carers consulted told auditors that they were fully involved in planning for their child.
- Plans across the service are not SMART (Specific, Measurable, Achievable, Realistic, Timely). They are often too generic and not updated with new or relevant information.
- Irregular multi agency meetings contribute to plans drifting and delays in the child and family receiving the right support.
- Drift is not always challenged by multi agency partners.
- When police have decided to take no further action in respect of sexual abuse;
 there is no ongoing consideration by the wider multi agency of sexual abuse.

4.2 Impact of any improvement or learning activity

- Good assessment training has linked assessment to planning. More work around analysis and critical thinking is planned with additional training to be offered around smart plans (February – April 2024).
- Audit performance data suggests some improvement in this area.
- Improving the quality of plans for children is crucial for our ongoing improvement journey. Practice improvement activity over the next quarter will focus on this aspect of practice.

5. Supervision and Management Oversight



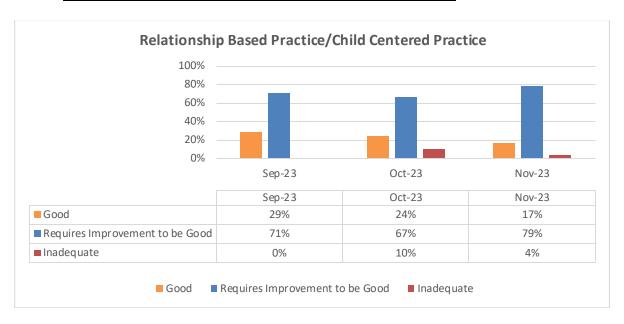
5.1 What do we know?

- Positively, supervision is taking place regularly across the service and largely within expected timescales. Also, there is evidence from recording that managers have a good knowledge of the families' practitioners are supporting.
- Evidence of reflective discussion does not always link back to the impact on the child
- Action setting and tracking requires improvement to drive plans forward in a timely way.
- There is not sufficient challenge from managers or IROs when actions are not progressed or there are delays in achieving permanence.

5.2 Impact of any improvement or learning activity

- Leeds colleagues have worked with Team Managers and others to improve practice leaderships skills by facilitating Team Manager training and action learning sets on management oversight and supervision. Sessions have involved managers sharing examples of management oversight and supervision records with others for review and feedback (show and share approach). In November 2022, 59% of audits were graded Inadequate for this domain; compared to 17% in November 2023 showing progress.
- Principal Social Worker will continue to offer quarterly action learning sets to managers to provide ongoing opportunities for reflection and sharing when our work with Leeds ends.
- All managers are now engaged in audit; managers tell us that by doing audits themselves and reviewing the work of colleagues; this allows them to reflect upon and improve their own oversight.
- The current focus for observation of practice is supervision; allowing practice to be observed in action; guidance and ideas to be shared; providing opportunity to further triangulate audit findings.

6. Relationship based practice - child centred practice



6.1 What do we know?

- Positively, visits to children and young people are regular and they are given the opportunity to discuss their wishes, feelings, and aspirations.
- There is also evidence of Social Workers building positive relationships with parents and engaging them in planning for their child (with one example of a memory box being shared to support understanding of life journey in the future).
- Changes in Social Worker/practitioners impact relationship building; often changes of worker are not supported by proper handovers.
- Use of direct work tools is limited.
- When direct work is undertaken; this is rarely analysed to consider impact on the child/ review how information gathered can support the plan.
- Delays in referrals being made to Family Group Conference service mean that support for families is not identified early on.

6.2 Impact of any improvement or learning activity

Leeds colleagues have over the course of the last 18 months supported Sefton to embed a family valued approach to practice. Child Centred/relational practice continues to be a strength with 21% of audits completed during October and November 2023 graded Good in this domain; 73% Requires Improvement to be Good and 7% Inadequate. Recent good assessment training has reinforced messaging around relational practice and Practice Week in October 2023 brought people together for further learning; with Sefton family members sharing their own lived experiences.

7. Creating Permanence

7.1 What do we know?

- Positive outcomes achieved for care experienced young people who have secure, stable accommodation and family support around them
- The main barrier to achieving permanence is that plans are not smart; or focused enough on achieving early permanence.
- Delays in court proceedings mean that permanence is not achieved in the right timeframe for the child or young person.
- Special Guardianship is not being revisited with long term foster carers in an ongoing way (following them indicating they do not wish to pursue SGO).
- Families are sometimes stepped down from a child protection plan without evidence of parents completing the necessary work or engaging in the plan. Auditors gueried rationale and impact on future permanence for the child.
- Family Group Conference could/should have been requested earlier to support permanence being achieved at the earliest opportunity.
- The absence of updated chronologies and full family genograms means that we do not understand the full history or current wider family support network.
- Absent transition planning to support young people into adulthood post 18.

7.2 Impact of any improvement or learning activity

- Practice & Performance Meetings bring practitioners and managers together on a
 quarterly basis. The focus in November 2023 was on achieving stability and
 permanence for children and young people. New guidance prepared by the
 Safeguarding & Review Unit was discussed and shared which sets out clearly the
 importance of legal, psychological, and physical permanence.
- In addition, a pilot audit tool focused specifically on permanence was created; to be tested in December and January 2024.

8. What children and their families are telling us

Auditors spoke to 8 children and young people during October and November 2023 and 30 parents/carers.

Of the 30 parents/carers spoken to -15 (50%) rated the service they had received as Excellent/Good, 9 (30%) as average and 3 (10 %) as very poor. 10% said it was "too early to say."

Of the 8 children/young people spoken to - 4 (50%) rated the service they had received as Excellent/Good, 2 (25%) as average and 1 (12.5%) as quite poor and 1 (12.5%) did not give a rating.

 "I attend all meetings and get copies of everything. The Social Worker keeps me informed in between meetings and I think things are progressing well."

- "The referral to Active Sefton has had the biggest impact on X as this helped his self-esteem and school attendance."
- "I don't know what more help could have been offered."
- "I have to prompt professionals for things and chase things up."
- "Mum had asked for a parenting programme a long time ago and the referral has only just been made; the situation deteriorated in this time."

Moving forward, and available for analysis in future reports there will be richer, more detailed engagement with families in respect of the service they are receiving. This work will be co-ordinated through the Safeguarding Unit and involve gathering the experiences of families who have experienced intervention at key planning points.

- 6 Month Child in Need Review
- 3-month Child Protection Plan Review
- At the point a Child Protection Plan Ends
- All children who have been the subject of a Care Order for two years or more

This ongoing dialogue with stakeholders will support improvement activity by connecting our view of the work we do with the experience of our children and their families.

9. Actions in Respect of Key Findings

There will be focused activity to improve plans and planning over the next 3
months with a particular emphasis on the importance of analysis. Practice &
Performance Meeting will take place on 18.03.24 as part of Social Work Week.
There will be a combination of training, one to one learning and reflective
discussions to support improvement.

10. Thematic dip samples undertaken during October and November 2023:

10.1. Quality of assessment in Help & Protect teams -

to obtain an "as is" picture before good assessment training was provided/become embedded within teams. 16 children considered in this dip sample. Findings as follows:

- It was positive to see that all the children being assessed had been visited at least once at home. In most of the records, the children's voice is recorded but generally in the Social Workers written account.
- Assessments were free from jargon and use plain language this is increasingly evident.
- In most assessments, the family history is captured but this would benefit from being reflected upon within the analysis to understand past strengths/harm and the impact this has had on the children.
- Assessing parent's capacity to change is not explored in detail.

Assessments would benefit from stronger management grip; using "check in"
points to reflect on progress, insights from family, child and partners which can
then be recorded as management oversight. Check ins can reduce drift and delay
and allow for clear practice direction to be given to the Social Worker to improve
the outcomes for the child and their family.

Repeat dip sample activity is planned for January – March 2024 to consider how well good assessment training has transferred to practice.

10.2. Re- referrals for Assessment –

to consider high number of re – referrals in the month of September/ explore rationale behind this; consider quality of first assessment, intervention, support, and planning that followed.

15 children were considered in this dip sample. Findings as follows:

- Out of the 15 screened, one family had a clear step-down plan, 3 were recommended Early Help but did not consent, 3 did not consent to anything post assessment, 5 closed with no further action and 4 assessments were closed that we felt should have remained open.
- 15 assessments did include an analysis within the assessment, however
 presented more like a description of the issues or risk and did not consider the
 impact on the child. There was limited evidence of tools or research being used in
 order inform the analysis.
- For children that had previously been assessed, it was not always explicit what had changed for the family since the previous assessment and the impact this had on the child. Assessing parent's capacity to change is not explored in detail.
- When Quality assuring assessments, there needs to be increasing focus on the 'Analysis' section this is vital in creating the plan for the family.

10.3. Repeat Child Protection plans -

Analysis of repeat plans is key activity in understanding the impact and effectiveness of intervention.

20 children were considered in this dip sample. Findings as follows:

- In more than half of the families (62.5%), the second period of child protection planning took place within 2 years of the previous plan stepping down.
- In almost all families (75%), the presenting worries were the same as previous.
- In all the sampling (100%), domestic abuse was a feature and the actions recommended in the Child Protection Plan had not been completed or a clear plan put in place at Child in Need (CIN) to complete this work.
- On a number of children's records, there was little evidence of reflection within the supervision notes of why the decision was made to step down to CIN and the evidence based planning used to support the recommendation to conference.
- When a CP plan is ended, there needs to be increasing grip around the Step Down activity for example ongoing Child in Need Planning.

11. Key Findings

- Vast Majority of practice is now graded as 'requires improvement to be good'
- 'Stubborn rump' of inadequate persists deficits in planning accounts for a great deal of this. Planning is the clear focus of improvement activity over the next quarter.
- Performance information continues to evidence improved conditions for better quality practice.
- Quality assurance resource needs to be balanced between 'measuring' and improving - dip sample activity, new formats of audits, practice observations and co-ordinated evidence driven improvement activity work towards addressing this.