APPENDIX 2 – Sandwell Children's Trust Performance Monitoring Report

Sandwell Children's Trust

Performance Monitoring Report

October 2018

Sandwell Childrens Trust Social Care Monthly Performance Statistics

Oct-18

PI.No	SANDWELL CHILDRENS TRUST KEY PERFORMANCE INDICATORS DESCRIPTION OF KPI	Frequency Calculated	Service Area	Better Performance is ?	Statistical Neighbour Average (where available)	England Average (where available)	West Midlands Average (where available)	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Change From August	Previous Three Month Average	Direction vs SN	Direction vs Eng	Direction vs Wmids
1.00	Percentage of contacts to MASH referral timeliness	Monthly	Front Door	High	No available comparator data	No available comparator data	No available comparator data	75.0%	86.0%	83.0%	74.0%	78.9%	81.7%	70.1%	82.8%	69.4%	57.5%	73.5%	▲	▲	N/A	N/A	N/A
2.00	Rate of Children on a Child Protection Plan per 10,000 CYP population	As at Month End	Front Door	Low	57.9	43.3	45.3	98.9	100.8	106.7	107.1	103.8	99.9	99.3	89.2	83	80.9	77.8	▼	▼	▲	▲	▲
3.00	Percentage of Initial Child Protection Conference (ICPC) in 15 working days	Monthly	Child Protection	High	83.9%	77.2%	78.7%	74.2%	80.9%	85.8%	88.9%	67.9%	92.3%	83.1%	80.6%	67.6%	71.7%	59.6%	▼	▼	▼	▼	▼
4.00	Out of the total number of open Single Assessments, the percentage of assessments completed within 45 working days	Monthly	Single Assessment Service	High	86.70%	82.90%	84.30%	92.4%	89.1%	86.8%	93.2%	86.9%	86.2%	80.3%	86.7%	89.6%	84.5%	72.0%	▼	▼	▼	▼	▼
5.00	Number of Children in need, including LAC & Children on Child Protection plan who have been unallocated for longer than five working days	As at Month End	Children in Need	Low	No available comparator data	No available comparator data	No available comparator data	7	40	46	45	61	17	12	7	38	8	13	▲	▼	N/A	N/A	N/A
6.00	Percentage of young people with Child Protection Plans where 2 weekly visits have taken place	As at Month End	Child Protection	High	No available comparator data	No available comparator data	No available comparator data	62.9%	80.9%	66.8%	73.8%	75.4%	78.1%	78.8%	76.6%	73.5%	69.3%	82.3%	▲	▲	N/A	N/A	N/A
7.00	% CP Plans in place and completed within six monthly intervals	As at Month End	Child Protection	High	No available comparator data	No available comparator data	No available comparator data	89.1%	86.9%	86.7%	90.6%	91.2%	94.3%	96.1%	95.3%	95.8%	96.9%	95.7%	▼	◆▶	N/A	N/A	N/A
8.00	Percentage of 4 weekly supervisions on Child Protection cases	As at Month End	Child Protection	High	No available comparator data	No available comparator data	No available comparator data	58.3%	41.0%	53.5%	67.2%	60.8%	69.2%	61.5%	59.8%	36.0%	58.6%	69.9%	▲	▲	N/A	N/A	N/A
9.00	% of Missing children return interviews within 72 hours	Monthly	Missing Children	High	No available comparator data	No available comparator data	No available comparator data	65.2%	23.1%	42.4%	39.1%	54.2%	92.3%	71.0%	57.9%	51.9%	71.4%	50.0%	▼	▼	N/A	N/A	N/A
10.00	% Children in Need Visited in the last 20 working days	As at Month End	Children in Need	High	No available comparator data	No available comparator data	No available comparator data	60.2%	65.2%	63.4%	57.8%	62.7%	64.0%	71.1%	65.9%	47.4%	55.7%	64.3%	▲	▲	N/A	N/A	N/A
11.00	Percentage Looked After Children visited in timescale according to statutory requirements.	As at Month End	Looked After Children	High	No available comparator data	No available comparator data	No available comparator data	90.2%	83.9%	87.8%	88.3%	87.1%	92.3%	87.6%	88.5%	89.0%	88.6%	90.5%	▲	▲	N/A	N/A	N/A
12.00	% LAC reviews within timescales -	Cumulative	Looked After Children	High	No available comparator data	No available comparator data	No available comparator data	71.60%	69.20%	66.70%	68.40%	77.90%	70.00%	76.70%	74.70%	83.90%	78.70%	79.00%	◆▶	◆▶	N/A	N/A	N/A
13.00	Vacancy rate of social workers **	As at Month End	Workforce	Low	20%	17%	19.20%	11.7%	15.3%	16.1%	26.8%	32.3%	30.3%	29.0%	32.1%	32.6%	30.1%	34.4%	▲	▲	▲	▲	▲
14.00	Average overall caseloads across Children's Services	As at Month End	Caseloads	Low	19.1	17.8	18.7	21.44	20.03	18.93	19.15	19.89	20.04	19.96	20.90	20.19	19.40	18.80	▼	▼	◆▶	◆▶	◆▶
15.00	Number of random monthly case file audits rated RI and above	Monthly	Quality Assurance	High	No available comparator data	No available comparator data	No available comparator data	No Audits	55.4%	50.9%	64.7%	55.6%	66.0%	40.0%	44.1%	61.7%	46.4%	54.8%	▲	▲	N/A	N/A	N/A

** PI 13 PLEASE NOTE ESTABLISHMENT WAS INCREASED IN FEBRUARY 2018 TO 220 STAFF FROM 184

Performance Summary

Overall, performance across several of the fifteen indicators has improved since the Trust went live.

- The rate of Children who are the subject of a Child Protection Plan continues to drop and this month it is 77.8 children per 10,000 of our population (631 children in total). Since April 2018 there has been a reduction of 198 children on a Child Protection plan. (PI29 provisionally to change to PI2). **The trend for Quarter 2 is a reduction from 83 to 77.8.**

- The number of children unallocated for longer than 5 working days has increased slightly to 13 as of 30 September 2018 with a further 28 cases unallocated for less than 5 working days. Daily performance reporting supplied on unallocated and embedding of the peripatetic team has improved timeliness of reallocating cases. (PI5). **The trend in Quarter 2 is a reduction from 38 to 13 cases.**

- The percentage of Children subject to a CP Plan visited within 2 weeks increased significantly from 69.3% to 82.3% in September 2018. Performance as an average since 1 April 2018 (76.4%) is slightly above March 2018 figure of 75.4% (PI6). **The trend in Quarter 2 is an increase from 76.6% to 82.3%.**

- Average caseloads have decreased across the service to 18.9 cases per worker with caseloads across the whole service becoming more manageable. Caseloads for each worker have reduced by an average of two cases since June 2018 (this is more noticeable in Care Management service where averages have reduced from 22.5 per worker to 18.2 over the same time period). Continued effort to reduce caseloads within the service with support from the beyond auditing team and the unwavering focus on recruitment and retention of social workers is a priority to reduce caseloads further. 508 cases have been closed between June and September 2018, and the number of Social Workers in post at the end of September was 205. (PI14) **The trend for Quarter 2 is a reduction from 20.19 to 18.80, with the greatest reduction within Care Management.**

- The percentage of case file audits that are rated Requires Improvement or better have increased for month of September 2018 to 54.8% from 46.4% in August 2018 since 1 April 2018 audits rated Requires Improvement or above is at an average of 52.2% which is slightly below performance of 55.6% in March 2018. Audits are being moderated in line with Ofsted inspection case file auditing process with improved closing the loop activity and Quality Assurance processes being embedded across the Trust (PI15). **The Quarter 2 trend is a reduction from 61.7% to 54.8%. However, the overall trend is a gradual increase from 40% in March 2018 to the current**

percentage of 54.8%. It is important to consider the nuance in comparing thematic audit outcomes month by month. This is outlined in detail in later sections.

- There have been steady improvements in the percentage of Children with an updated Child Protection Plan within the last six months from 91.2% to 95.7% although this performance has decreased slightly on August figure of 96.9% (PI7). **The trend in Quarter 2 is one of stability 95.8% to 95.7%.** The reduction of average caseload across Care Management Service has contributed towards the overall improvement since April 2018.

- There continues to be an upward steady trajectory in the percentage of Looked After Children visited in accordance with statutory requirements as at the end of September the performance is now 90.5% which is a 3.4% improvement on March 2018 (PI11). **The trend for Quarter 2 is that this indicator has remained stable.**

- At the end of September 2018, there had been a significant increase in the percentage of children on CP plans with a case supervision held within the previous 4 weeks. This has increased from 36% to 69.9% over the last two months. The impact of weekly performance board meetings has seen a positive shift in performance over the last two months and will continue to be scrutinised to ensure further progress in this measure (performance is now 8.1% above March 2018). **The trend in Quarter 2 is an increase from 36% to 69.9%. Whilst this appears a huge increase, on average, since April 2018 improvement in this area has been steady. Children in Need visits completed within 28 days has also increased from 47.4% to 64.3% in Quarter 2 (PI8 and PI10).**

- The vacancy rate of permanent front line Social Workers has increased to 34.1%. However, the number of these posts that are unfilled by either a permanent or agency worker is 23.2 (including long term sickness and maternity leave), which represents 10.5% "unfilled vacancies" (PI13). **The trend in Quarter 2 is an increase from 32.6% to 34.4% of permanent social workers. However, as described the actual unfilled vacancies is only 10.5%.**

- The percentage of Single Assessments completed within 45 working days has decreased to 72% in September 2018, this is primarily due to working on the backlog to complete and Authorise assessments which are over 45 days and has in turn affected the figure for the last two months. It is important to highlight that since the end of August 2018, 75 out of 141 overdue assessments have been completed reducing the number of assessments open over 45 days to 66 in September 2018. Performance is therefore expected to improve in the coming months. It is worth noting that the cumulative position across the service is at 83.2% since 1 April which

is in line with latest comparator data. **The trend for Quarter 2 is a reduction from 89.6% to 72%, but as described this is due to clearing the backlog of overdue assessments and is expected to rise in the next quarter.**

- The percentage of Looked After Children's Reviews held within statutory timescales (recorded on LCS) is too low (at 79%). Exception reporting for LAC reviews found that the real percentage of this measure is 94%, and the discrepancy is that these are not recorded on the case management system work is underway to ensure that cases are updated in a timely manner including updating the Childs Looked After Plan in a timely way. (PI12). **This has reduced from 83.9% to 79% over Quarter 2.**

- The percentage of young people returning from a missing episode who have had a return interview within 72 hours has decreased in September to 50%, although the cumulative position is at 65.8% since the 1 April 2018. This represents an overall average improvement in comparison to March by 11.6% (PI9). **The trend in Quarter 2 is steady at around 50% with a spike to 71.4% in August 2018. We are reviewing our contract with Barnardo's and will drive improved performance in this area.**

- The percentage of contacts accepted as a referral within 24 hours increased by 16% on previous month to 73.5%. (PI1). **The trend in Quarter 2 is a steady upward trajectory from 69.4% to 73.5%.**

- There has been a significant reduction in Initial Child Protection Conferences held within the Statutory timescales in September 2018 (PI13). **The trend for Quarter 2 in this area is a reduction from 67.6% to 59.6%. This is due to seven families whose conference was delayed due to late notification and no S47 in place.**

Quality Assurance Activity

This report provides a summary of the findings of the quality assurance activity undertaken during September 2018 and outlines the key findings and themes. In addition to reporting on all the QA related activities undertaken in September, this report will also provide an update from audit activity undertaken via LSCB in Q1 and Q2 of 2018. This will bring us up to date with all the QA reporting, till date. This report will also provide information related to our Learning and Development Service and how learning from QA activities are being used to inform our priorities in L&D.

During September 2018, the Quality Assurance Service undertook the following activities aimed at better understanding the quality of practice:

- Audit activity across the service following the QA framework. The theme for this month was Section 47 enquiries.
- Update from Learning and development
- Work undertaken by the Beyond Auditing Team.
- Focussed QA intervention with Children with Disabilities Team.
- Continuous oversight, support and challenge from the safeguarding unit.
- Performance monitoring following scrutiny of data from the performance dashboard.
- Learning from compliments and complaints.
- Update from LSCB audits – Q1 and Q2.

This report gives a summary of findings and actions from various activities undertaken that are mentioned above.

1. Summary of Key Findings from Monthly Case File Audit Activity during August 2018

Table 1: Overall audit performance and ratings, measuring progress since last month

Service	August Audits		G	RI	I
	Target	Actual			
Quality Assurance Children's Audit Activity	55	47	5 10.6%	21 44.6%	21 44.6%
Moderations	25	29	0 0%	13 44.8%	16 55.17%

August 2018		
G	RI	I
3 11%	10 36%	15 53%
0 0%	11 39%	17 61%

A total of 55 audits were sent out for completion in September. The theme of audits was section 47 enquiries. Managers were requested to audit the whole case file with a special focus on the relevance and robustness of our child protections enquiries – which included the strategy discussion and section 47 investigation. Cases were selected from all parts of the

service – front door (including MASH and SAAT teams), care management, and Looked after service, even though a bulk of cases from the sample were from the front door. This was done to allow us a balanced perspective of our child protection processes followed across the entire service, whilst scrutinising the robustness of our front door where majority of these investigations are conducted.

Table 1 shows the overall performance with audit returns and how the quality of our overall intervention was rated by managers, before and after moderation. It also tracks our performance in terms of lifting the quality of practice since last month. It must be noted, that there is improvement noted both before and after moderation of the audits. The quality of our work requiring improvement has increased from 39% to approximately 45%, and the inadequate rating has reduced from 61% to 55%. Both these measures demonstrate a move in the right direction whereby the service being delivered by the service is progressing from inadequate to RI.

Compliance update:

Table 2: Overall compliance in September 2018

Total number of audits expected	Total returned	Overall compliance	Moderations expected	Moderations completed	Moderation Compliance
55	47	85.4%	25	29	116%

Compliance with audit returns this month has been approximately 85%, which is a marked improvement from previous few months. Whilst this improvement needs to be celebrated, all efforts have to be maintained to keep the momentum going and ensuring high compliance in future. It was agreed that approximately 50% of returned audits would be moderated to inform the findings in this report. In actual, a higher number of moderations needed to be completed to ensure we have a balanced feedback for all parts of the service. The quality of completed audits were also variable, as can be seen from the findings. All the audits rated as good by the auditing managers were downgraded, with two being downgraded to inadequate, of which one was an inadequate escalation.

Summary of findings from audits:

Overall findings from all 47 audits that were completed are shown in the following table. These are the findings prior to moderations:

Table 3: Detailed findings from all completed audits (47in total).

Parameter	Good Approx. Percentage	Requires Improvement Approx. Percentage	Inadequate Approx. Percentage
Quality and impact of earlier intervention	9 19.14%	18 38.29%	20 42.55%
Assessment and Analysis of risk	7 14.89%	19 40.42%	20 42.55%
Plan	7 14.89%	15 31.91%	20 42.55%
Review	6 12.76%	15 31.91%	15 31.91%
Voice of the child	4 8.5%	21 44.68%	19 40.42%
Supervision /Management Oversight	7 14.89%	20 42.55%	18 38.29%
Impact on the child	10 21.27%	15 31.91%	18 38.29%
Impact on the family	10 21.27%	15 31.91%	18 38.29%
Overall	**5 10.63%**	**21 44.68%**	**21 44.68%**

The findings from all moderated audits (29 in total), have been collated with the audit tool being broken down into the key areas of practice which is presented in the table below. It must be noted that where areas pf practice fell into the RI category this was often due to evidence of procedures being followed, however practice still fell short of being judged as good. Most of the cases deemed to be inadequate were primarily due to evidence of poor practice in relation to application of thresholds, quality and timeliness of assessments, plans, reviews and supervisions/management oversight.

Table 4: Detailed findings from moderated audits (29 in total).

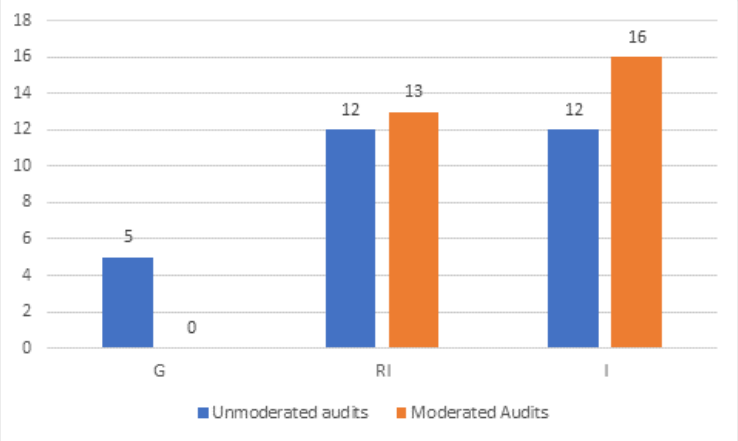
Parameter	Good Approx. Percentage	Requires Improvement Approx. Percentage	Inadequate Approx. Percentage
Quality and impact of earlier intervention	0 0%	9 31.03%	20 68.9%
Assessment and Analysis of risk	1 3.44%	10 34.4%	18 62%
Plan	1 3.44%	10 34.4%	17 58.6%
Review	0 0%	10 34.4%	15 51.7%
Voice of the child	1 3.44%	15 51.7%	13 44.8%
Supervision /Management Oversight	1 3.44%	13 44.8%	15 51.7%
Impact on the child	2 6.8%	12 41.3%	15 51.7%
Impact on the family	3 10.34%	10 34.4%	16 55.17%
Overall	**0** **0%**	**13** **44.8%**	**16** **55.17%**

During the moderation process, it was evident that the overall quality of audits is improving. They are better written and presented, with managers making time to explain their judgement. There are still some cases where poorly written audits have been submitted, and feedback has been provided to each of those managers. An additional audit training day has been scheduled on 18th October to support any managers – new and existing, on how to complete good audits. There will be 1:1 support for managers who wish to be supported on the audit days (already scheduled in diaries) going forward. The moderation process also highlighted that whilst most manager's overall judgements are in line with Ofsted grade descriptors, their rating of aspects of case work varies. This finding is also reflected in table 3 and 4 above where variations can be seen across all parameters. This demonstrates that manager's understanding of what good practice looks like needs further refining so that their expected standards of practice can be raised. Work is currently being undertaken by the head of safeguarding to refine our practice standards, and align it to the process maps defining work flow in various parts of the service. Once this is complete, plans are for it to be launched

and training to be provided to all new and existing staff to familiarise them of our renewed practice standards. This will set clear expectations in terms of quality of practice across the board. The following table shows the overall variance in ratings in the cohort that was moderated:

Table 5: Overall comparison of ratings before and after moderation.

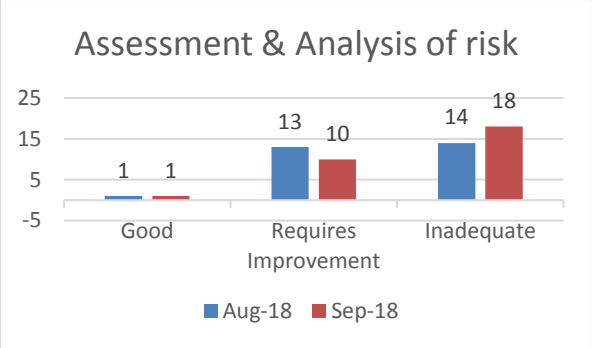
Audit type	G	RI	I
Unmoderated audits	5	12	12
Moderated Audits	0	13	16 (incl. 3 escalations)

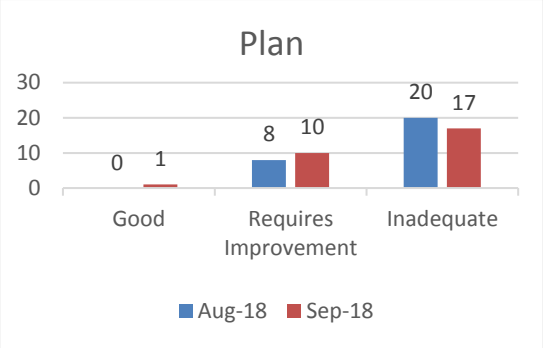


Of the audits rated as good – 2 were moderated to be inadequate – of which one was an inadequate escalation for management response. Remaining 3 were moderated to be RI, of which 1 with strong evidence of good practice. A further 2 audits which were initially rated as RI were downgraded to be inadequate. All managers have been offered detailed feedback and support to assist in building their understanding of what good looks like. Their line managers have also been informed so that continued support can be offered in the form of coaching and mentoring.

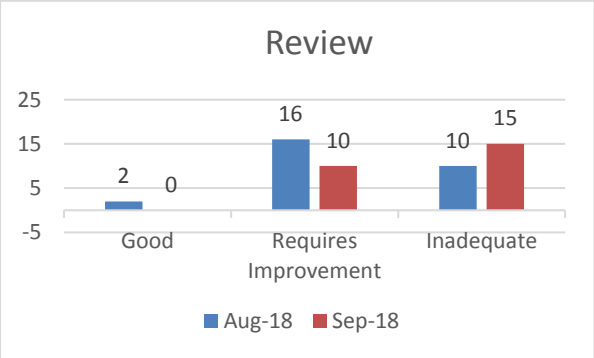
Measuring improvements in quality of intervention month on month:

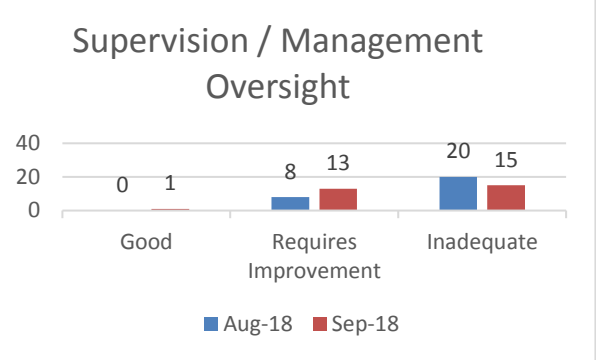
We plan to track any improvements reporting by auditing activity in future. This will evidence any improvements made, and will also assist in informing out strategies to support the service in raising service standards. The following diagrams demonstrate progress made (if any) since last month, across various parameters of social work practice:



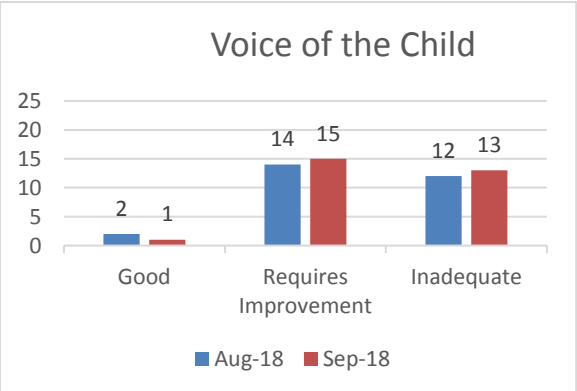


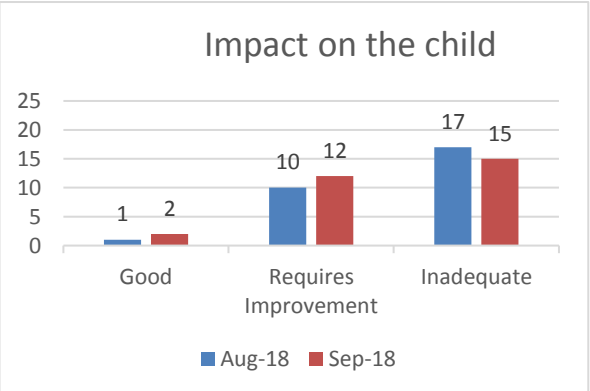
The above two charts show that the quality of our assessments continue to remain weak with the number of inadequate assessments/risk assessments showing an increase. Assessments inform the plans for the child. If assessments are weak, it is likely that the plans will not be as robust. In the above chart, we see that out plans need to be strengthened to ensure the right outcomes are being achieved and a positive impact is being made on the child.





The review process alludes to independent oversight for CP and LAC cases, and social work oversight on CIN planning process. Supervision/management oversight is a method of offering support and direction to case planning, along with independent overview by the IRO service. Collectively, this should work to provide checks and balances and overall support required to achieve positive outcomes for a child and family. The above two charts demonstrate that our practice within these very important mechanisms remains weak, and there is a need for it to be strengthened swiftly if any improvements in casework is to be registered.





The above table shows that we are improving at securing the voice of the child. It demonstrates greater social work commitment to make time to see children, and use appropriate tools to secure their views and feelings. It is worth noting that whilst we are improving at establishing the views and wishes of children, the impact on child is recorded as low. The reason behind low impact of our intervention is because we need to get better at understanding the lived experience of our children by securing meaningful voice of child. This information then needs to find its way into our assessment and planning process. Supervision/management oversight and independent review mechanisms need to be strong to support this process and provide direction. Due to poor management oversight and threshold establishment at an early stage, children continue to suffer and plans remain ineffective to create a positive impact on the life of the child. These are our areas where practice needs to be lifted, and improvements made swiftly.

Findings around the theme of audit – Section 47 process:

What is working well –

1. The process of section 47 or child protection process is clear and well embedded at the front door.
2. Contacts coming in are largely processes swiftly and sent to MASH for decision. MASH discussion takes place in a timely manner and decision is communicated to managers to progress the referral, once the child protection concerns are established.
3. Strategy discussion is also held in a timely manner, and by virtue to being held in MASH, these meetings are largely working together compliant.
4. Section 47 investigations are also predominantly completed in a timely manner with a clear management oversight recorded for further actions.
5. Where necessary, initial child protection conferences are also held within 15 working days from strategy meeting.
6. Some assessments are detailed, and capture information appropriately.
7. Social work initial visit to the child and family following the strategy meeting at the front door are usually within acceptable timescales (mostly within 24 hours, at the front door).
8. Children are seen and spoken to on their own and their wishes and feelings are clearly recorded on case file.
9. Multi agency information sharing is good at the front door by virtue of having MASH.
10. Where a need for swift response to safeguard a child is identified i.e. working with police to exercise powers of police protection, or indeed securing a court order to safeguard a child, these decisions and processes are completed with good partnership working at the front door.

What we need to improve –

This section has been broken down into two sections – general areas for improvement which appear to apply to all parts of service, and specific findings for different parts of the service i.e. front door (MASH and SAAT), and Care management and LAC service.

General findings:

1. Child protection investigations i.e. S.47 enquiries need to be made robust by timely relationship building with families through prompt visiting once investigations are initiated. Visits need to be made as often as needed, and all actions taken (medical, ABE etc) need to be recorded meaningfully in the investigation document.
2. Investigations need to include views from all relevant partner agencies to inform the outcome of the investigation, ensuring we speak to absent fathers, and ensure that our investigation is informed by evidence and meaningful voice of the child. Most of these areas appear wholly missing in our current investigations, which renders our risk assessments superficial and therefore future plans appear misplaced or lacking grip and direction.
3. All section 47 investigations are not always followed by a robust single assessment (as they should do). Sometimes there is no assessment done at all. This practice needs to be changed and due diligence needs to be applied in following process, meaningfully.
4. The assessments, when completed, often lack depth in understanding the cycle of abuse. They focus more on 'here and now' rather than considering history, promoting lateral thinking and deriving evidence based analysis.
5. Our analysis becomes over-optimistic as we seem to be relying on self-reporting by parents to inform our assessments, without challenging families to test the validity and depth of information they volunteer. We are not very good at seeking relevant information from partner agencies. In section 47 investigations, where there is any discrepancy in information provided by two agencies, it needs to be clarified to reach a reasonable conclusion, rather than muddling through the information and concluding that the concerns about the child remain unsubstantiated. Such approach may allow meeting the timescales of a process, but almost never provides one with the root cause of any issue.
6. Another area of weakness is our inability to work with 'hard to engage' families. A majority of our section 47s seem to be carried out where domestic violence is a prominent risk factor. In such cases, it is essential that social workers understand the importance of 'power and control' and how it impacts in the way people behave. To decide that the family is not willing to engage is easy, to understand what lies behind that non-engagement is what is required. Only then we can tailor our approach with these families, and understand the value of what remains 'un-reported or not said'.
7. It is well known that our assessments remain weak and lack evidence due to lack of appropriate tools being used to understand and measure abuse such as neglect, DV etc. This finding still holds in these audits as well. Our child protection investigations, and outcomes are compromised because we seem to fail to articulate the extent of needs and risks associated with each case. Our approach to problem solving therefore is often misplaced and watered down, or not provided at the right level (thresholds) at the right time.
8. Often Chronology and Genograms are missing which shows their importance is not understood well throughout the service.
9. There needs to be a better understanding and rigour around Connected persons/family and friend's placements. Currently family placements are being made without a full appreciation of the legal impact of those arrangements.

Specific learning for Front Door: All the general findings mentioned above apply to the front door. In addition to those, the service specific findings are:

1. Whilst the child protection process is followed appropriately and managed in a timely manner, there is a need for attention to detail. The MASH information gathering is good; however, it lacks robust analysis and decision making. This shows that we are not making the best use of MASH arrangement by adding value to information on file.
2. Information gathered within MASH document remains primarily in EH module, rather than finding its way into LCS to support decision making around thresholds. Even if the information is sent to social care, a lack of strong analysis at the initial stage most often slows/skews decision making going forward. There are cases which have been closed/stepped down for EH support, when clearly thresholds for further enquiries/assessments were met. If only there was appropriate reflection on past and current information held within MASH, initial thresholds could be well established.
3. Once the cases are referred to social care for a strategy discussion, whilst these discussions are held in a timely manner, they mostly repeat the information from MASH case discussion. Whilst most of the strategy discussions in SAAT are working together compliant, it is not clear if they are so by virtue of proximity to MASH or if they are actually liaising with the professionals associated with the family, which would allow sharing of most up to date information. In more straightforward cases, these strategy discussions are able to come to a reasonable outcome. However, where the cases are complex, mostly strategy discussions at front door are lacking depth and rigour in foresight and decision making. They seem to be led by police investigations, rather than having a joint perspective on risks and case management.
4. Decisions like outcome of MASH, threshold decision, strategy discussion outcome, and section 47 investigation decisions lack a clear rationale. It is essential to explain rationale for clarity and accountability.
5. Application of thresholds at various levels of decision making are often compromised due to poor assessment and analysis, especially pre-birth. Assessments need to be improved by using information from history, consideration of information from all 'relevant' partner agencies.
6. Assessments are not always individualised in order that the needs and risks to individual child are fully understood. Part of this problem may be that we do not promote holistic understanding of situation. However, a major issue appears to be that assessments are completed based on one visit or not even that. Information collated from the section 47 visit is used to inform assessments. We need to visit the child and family at planned intervals to complete an assessment which can be further strengthened by including the child's lived experience, their views, wishes and feelings. Better quality assessments would inform planning, appropriate decision making and threshold application more accurately.
7. Attention needs to be given to children's needs relating to disability and identity. Currently, whilst the disability may (or may not) be recorded, information is not used to understand how it impacts on the holistic needs of the child. Similarly, the child's identity, needs to better relate to their culture and heritage.
8. Social work practice need to make a more determined approach to understanding the lived experience of a child in order that informs the child's plan. There is a need for more effective direct work with children and families.

9. The Voice of the Child is being captured, but not meaningfully. Also, there needs to be an understanding that Voice of the Child needs to be used to inform the care planning.
10. Quality and impact of supervision needs strengthening. There is management oversight, which may be useful in cases with low level concerns. Where we are dealing with complex issues, an in-depth supervision is needed to promote professional curiosity and offer support and direction at the right time. Disjointed management oversight in various documents/times does not appear to be effective in understanding gravity of concerns, and offer direction to the case.

Specific learning for CM and LAC service – All the general findings mentioned above apply to Care Management and LAC teams. In addition to those, the service specific findings are:

1. Section 47 enquiries are usually made in these services on existing cases. The teams usually have a knowledge of families which are already open to them. It is concerning that in majority of cases audited, the child protection process does not seem to start as soon as concerns are identified. There is a delay (sometimes concerning length of delay) in initiating these enquiries without any rationale given to explain the drift.
2. Strategy discussions are often not WT complaint, and at best are held with only police.
3. There is further delay between strategy discussion and section 47 investigations, which is unacceptable. Usually child protection concerns in these teams are real, as they are based on some evidence known to the teams. Any delays, therefore, in completing the investigation process is unacceptable.
4. Examples have been seen where another strategy discussion has been recorded, perhaps only to demonstrate that the 15-day indicator has been met. This practice must be stopped as it will show that we are doing more investigations than we actually are. Drift and delays need to be dealt with, learning made, and practice needs to be improved for future.

Specific learning for IRO service –

1. Even where concerns are established, the CP plans that follow are weak due to weak assessments. The IRO service needs to offer independent oversight on cases, and offer constructive criticism to bring the case back on track. Instead, the service currently seems to follow decisions made by the social work team, thereby offering little challenge, and adding little value to the planning process.
2. CP plans seem to rely heavily on parents to make positive changes. It must be understood that it is these parents who have contributed to the cycle of neglect/abuse over many years before concerns get established. Parents will not be able to bring a positive change without support. This support, and the accountability of change needs to be clearly defined, and allowed reasonable time within the child's timeline to register change.
3. When change is not registered within the agreed timeline, the IRO service needs to provide an overview, and advocate on behalf of the child. This needs to be done using appropriate tools to register IRO concerns with relevant agencies, and robust oversight to be provided to prevent drift and delay. Currently this is not routinely done.

Actions taken to impact change –

1. All moderated audits have been shared with auditing manager, and the social work team in order for learnings to be made. One to one support has been offered, and taken, to discuss how to complete a good audit, and rate a case based on evidence in case file.
2. Learning from the audit activity is shared with all OMs and GHs in a meeting chaired by the Director of performance and QA on a monthly basis.
3. Learning from these audits are included in the bite-size trainings for TMs, aspiring TM training which is also open to IROs, and in ASYE support sessions. This is with a view widen the scope of learning and reflection in the service.
4. These audits have identified major concerns around uniformity of following child protection process across the board. In order to bring uniformity in practice, work is currently being undertaken under the overall leadership of Group Head Safeguarding and Quality Assurance to revise our practice standards, and process map for basic social work processes. These revised practice standards and process maps are planned to be launched and widely disseminated to all staff across the service to ensure everyone is clear on expectations of the Trust when completing core social work tasks, including child protection investigations.
5. The issue about MASH information not finding its way meaningfully into referrals has been discussed with senior management, and there is a commitment to address this issue. Director of Quality Assurance will be overseeing progress on this matter through the 12-week improvement plan for the front door.
6. Decision making at every stage needs to be explained using appropriate rationale. This message will be communicated to the group head for front door so that this matter can be addressed. This learning will also be included in practice standards, to ensure uniformity of practice across the board.
7. The section 47 template on LCS is not the most conducive to record all activities undertaken by a social worker. Social workers therefore use the document creatively, and sometime the recording is not effective. There is a task and finish group looking at enhancing this document which should address this matter in future.
8. The issue of social workers needing tools to assess issues like neglect and DV has been well known. Social work tools have now been approved for use and will be launched at the Sandwell Children's Trust Staff Conference on 19th October 2018. Social workers will need further training for using these tools, and L&D service will be planning to roll out training in this area.
9. There are direct workshops planned to support staff with various themes like – work 'with' families and not 'to', re-boot on signs of safety framework, basic safeguarding, reflective supervisions etc.
10. IRO service is starting to look at Mid-Point audits. Activities are underway to develop a tool and train IROs to complete these audits. It is expected that this will start by 1st December 2018.
11. Discussions are being held with L&D service to revamp our training offer as it currently does not meet the needs of the service holistically. There is a need for training around 'hard to engage/resistant' families, section 47 investigations, identifying neglect, understanding thresholds for various services etc.

2. Update on Beyond Auditing (BA) Activity

BA team was back in Care management 2 and 12 for re-audit. These teams had BA intervention in May/June 2018, and now the teams were re-audited to evaluate how well the teams had embedded learning from the initial BA support, and to assess the efficacy of BA intervention.

Re-Audit Judgements and Brief Overview of the Findings

CM2 - 10 cases were re-audited and these were a combination of full audits and dip samples. One of the cases that was audited has now moved to LAC.

Audit Rating/Month	Good	RI	Inadequate	Inadequate escalation
May/June 2018			8	2
September 2018			9 (1 case has moved to LAC)	1

What is working well?

- In a couple of cases where supervision was present, it was more detailed including actions informing the plan.
- In relation to a couple of cases a DRP was raised by the IRO due to concerns about the drift and delay that was evident

CM12 - 11 Cases from the original BA cohort re-audited. However, one of the cases has been closed and another has transferred to LAC.

Audit Rating/Month	Good	RI	Inadequate	Inadequate escalation
May/June 2018	1	3	7	
September 2018		4	4 (1 case has moved to LAC)	2

What is working well?

- Within a few cases, regular supervision was noted which was more detailed and included actions.
- In one case, there is evidence of robust IRO oversight of the planning for the child including discussions with the social worker, team manager and adoption team

manager in respect of each potential option and the implications of each for the child. In another, a DRP 3 has been issued due to significant drift and delay in progressing children's care plans.

What are we worried about?

The learning points for both teams were on similar lines, and therefore have been amalgamated as follows:

- Overall, supervision has not been taking place regularly and the management oversight is not robust in providing SW with the case direction required to enable effective interventions and timely outcomes to be achieved for children. Management oversight needs to evidence a robust response to risk and care planning to achieve long term positive outcomes for children.
- BA audits have not been routinely used as a learning tool to understand the issues in the cases, ensure that the actions are progressed and lift practice. Delay in the action plan identified as part of the conclusion of BA in June has not been progressed.
- In the three CP cases that were stepped down from a CP to CIN, Auditors were unable to determine what evidence was being used to evidence that the risks had sufficiently reduced and could be sustained.
- Overall, difficult to identify what difference is being made to the children. Very little evidence of risk being reduced through appropriate intervention despite statutory involvement.

Beyond Auditing Recommendations

1. OM's to continue to monitor the progress of the BA cases by the TM to ensure that audit actions are completed and the cases progressed every month from the 15.10.18. IRO to also ensure oversight of cases audited overseen by the IRO TM.
2. BA Manager to review case note alerts for all BA cases to ensure that the BA Auditors have work flowed the cases to all OM's, IRO's/IRO TM's and GH's to support continued oversight of these cases by 15.10.18
3. OM and TM to devise a TM support plan which focuses on strengthening care planning skills, securing more timely outcomes for children, improving the team performance, the quality of the TM oversight to secure better outcomes for children by 31.10.18.
4. TM to attend the five Management Impact Workshops to strengthen practice from November -December 2018.
5. Group Supervision to be held every month by the OM's with the TM's and separately with the IRO's and the IRO Managers to continue to provide spaces for critical reflection on practice informed by the learning from audits, complaints and SCR's to strengthen practice. Impact needs to be measured and reviewed from November 2018.
6. GH's (operational and safeguarding) to ensure that service events also provide the same reflection and learning (as outlined in action 5) identifying how the impact can be tracked from November 2018.

7. OM's to dip sample assessments and the plans monthly to ensure that TM's quality assurance of assessments, informed by chronologies and genograms and plans are robust and provide the necessary challenge if they need to be improved.
8. GH's and OM's to consider how the drift and delay evident for children particularly at transfer points within the child's journey (particularly from SAAT to CM and CM to LAC) can be reduced resulting in more timely interventions as part of the work undertaken for OFSTED Preparation.
9. The Quality Assurance Service to develop a mechanism to dip sample' and review the progress of audited cases particularly those that have been rated as inadequate escalation or re-audited as part of the BA programme are reviewed the performance boards by 31.10.18.

3. Update from LSCB Audits – Q1 and Q2

LSCB organised Multi-Agency audits in quarter 1 to assess 'Multi Agency partnership response to Child Protection'. These audits were completed in May and June 2018. The audit findings, and 7-minute briefing from this audit activity has recently been circulated to all partner agencies for wider dissemination and learning in each agency. The main recommendations from this audit activity were:

1. Regular professional's meetings should be held with all agencies in attendance to assist in documenting the information shared and ensuring all agencies are cited on the risks both current and historic

2. Consult the regional safeguarding procedures to utilise the SSCB escalation policy if required, especially where actions from previous core group meetings have not progressed

3. Professionals to request copies of the child's plan and core group minutes and ensure these are reviewed in each meeting.

4. Safeguarding is everyone's responsibility. Ensure that at all stages of the process accurate actions and decisions are recorded (on the child's file) and shared with relevant personnel (including the worker who raised the initial concern).

In Quarter 2, the theme was 'Multi-Agency response to targeted Services and the Lead Professional role'. The audit findings and 7-minute briefing from these audit themes will be consolidated and circulated to all partner agencies shortly. The main recommendations from these audits were:

Recommendations for Seniors/Managers:

1. Managers/seniors to be more vigilant in their oversight of cases, and to attend "Core Working Together", at least once every 3 years, and relate the aspects of Professional Curiosity to be used in relation to supervision of cases.

2. Supervision of cases to be consistently reflective, looking at family history/dynamics and build into supervision structure to examine why services are involved with this family in the first place.

Recommendations for Frontline Practitioners:

1. Practitioners should complete regular chronologies and family histories, to ensure that they are getting the 'big picture' and not just focusing on the presenting problems. Also ensuring that they are working with the whole family, to give a holistic approach to ensure effective change that can be maintained.
2. Evidence that practitioners are actively seeking to gain consent to work with the whole family, and exercising professional curiosity if families are only consenting for work with certain child/ren. To ensure that practitioners are working on all areas needing support, not focusing on what the parents are stating the children's needs are.
3. Ensure that the right agencies/individuals are invited to multi-agency meetings, and when agencies fail to attend that this is escalated to seniors within their organisation by other members of the group.
4. Professional disagreements to be resolved outside of the meetings, and if they cannot be resolved, to be escalated.
5. Good practice guide to be developed for TAF/Core Groups, focusing on when a case is stepped down from Targeted Services and/or another Lead Professional takes over to ensure a consistent approach to the support offered to the family.
6. Showing evidence of persistence, professional curiosity, and creative methods of engaging with families, through accurate and timely record keeping. Practitioners should attend "Core Working Together" training at least once every three years.

The theme for Q3 of LSCB audits is around CSE and Missing. The findings from these audits will be reported in due course once they are consolidated.

4. Final Summary

This report continues to bring together all QA related activities being undertaken in Sandwell Children's Trust.

It gives the Trust a better insight and understanding into our direction of travel, and issues that need to be resolved and improvements needed in order to achieve a good standard of practice which delivers timelier and much improved outcomes for the children and young people of Sandwell.

The Audit teams work tirelessly to triangulate their findings and report to all parts of the service through various meetings and forums with a common goal of raising practice standards.

This is done with a view to tailor future training needs of workers and managers, the ASYE and Aspire programme, and support the service in their improvement journey.

Whilst services continue to steadily make improvements, the various audit processes highlight the fact that practice needs to continue to develop and improve in critical areas such as IRO oversight and supervisions, direct work with children to understand their lived experience, and use of good timely assessments and voice of child to inform care planning. Monthly audit activity has also highlighted the need to accurate threshold application at each level and concerns to be raised in a meaningful manner with places accountability of actions of responsible professionals.

There is also a need for managers and workers to be held more accountable for their roles, and supported within an enabling environment. This accountability needs to be extended when closing the loop, and taking responsibility to ensure learning from audits are reflected upon to improve practice. Going forward, Care planning is an essential area that needs to be strengthened and plans are already underway to streamline the process which is expected to offer clarity and support to the workforce. Focussed sessions have been planned to be rolled out to managers across the service in the following months. These sessions will be informed by learning from audits and will be aimed to strengthen management decision making at various stages of care planning.