Telford & Wrekin
Co-operative Council

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Telford and Wrekin

Quality Assurance Annual Report

2022-2023

Ofsted
Outstanding
Provider

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INTRODUCTION

INTRODUCTION

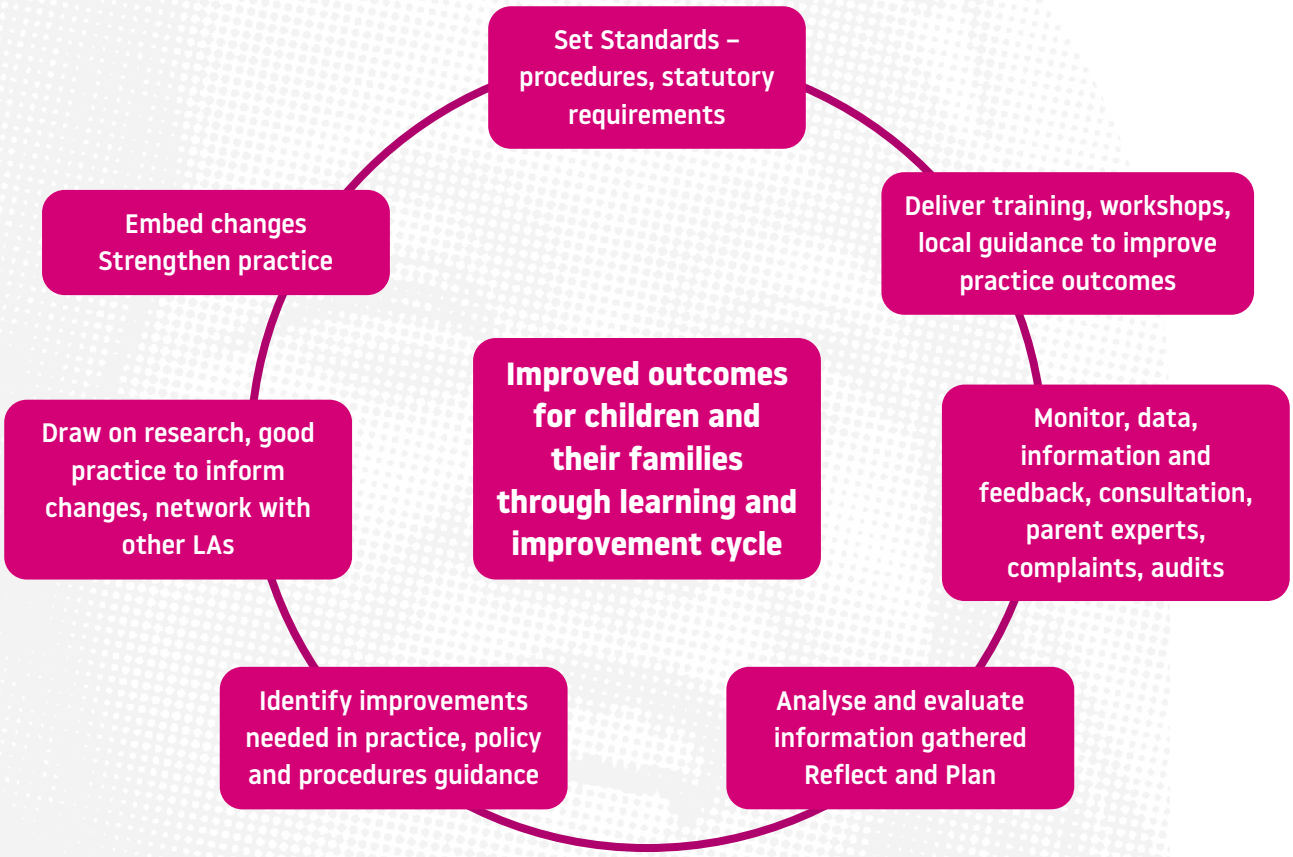
The quality assurance annual report brings together our activity throughout 2022-2023 and links closely to our Children's Services Quality Assurance Framework and Practice Framework. Since being graded as an outstanding authority in January 2020, we have also produced our Maintaining Outstanding document, which incorporates good practice nationally and provides some helpful guidance for practitioners. We know that there is always room for improvement and recognise the importance of working together as a service to refresh and re-visit arrangements to assure ourselves that practice is as good as it can possibly be, as well as continuing to look at ways to further improve. "Success can lead to complacency, and complacency is the greatest enemy of success".

Over the past months, we have also had a focus on "back to basics", undertaking some deep dive auditing, reviewing our performance, refreshing policies and monitoring mechanisms, to streamline our processes. We have held conferences for our staff and partners, held workshops and task and finish groups, and identified opportunities to share good practice, by sharing internal creative approaches and learning from external research and good practice.

Our Practice Framework talks about working collaboratively with children and their families, underpinned by language that cares, whilst encompassing our overarching values and commitments to delivering the best possible outcomes for all children and young people. The implementation of the Family Safeguarding model provided the opportunity to re-examine our approaches across children's services and commence reframing our service provision, delivery and practice approaches, moving from an expert-professional approach to bringing the wisdom of lived and learnt experience together, fostering principles of collaboration to bring change. We have started to hear from families, how positively they have received the collaborative, relational approach of the Family Safeguarding model of practice, extracts from some of the feedback can been seen later in this document.

We have also formed a parental partnership working group with practitioners who are committed to changing the narrative and approaches in relation to child protection and support. The group have explored the internal changes we can make to ensure parents are listened to, valued, and treated with respect. They looked at how we foster collaboration by ensuring that parents are not just recipients of services but are seen as experts because of their lived experiences. To build on this we collaborated with colleagues from Relational Activism – a group who have pioneered co-production with parents and families. They provided the scaffolding and framework for our new parent participation group, the 'Dandelion Group', made up of parents with lived experience of our system.

Our learning loop shown below demonstrates how we want to use our quality assurance arrangements to ensure that our activities result in us considering any findings, re-thinking our current arrangements, planning appropriately, and making improvements that need to be made to improve outcomes for children.



1.1 What do we want to achieve?

- We want to gain insight into what is working well and what is not.
- We want an improved understanding of what families think about how we collaborate with them.
- We want recordings to reflect a child's journey in language that is respectful and that explains why decisions were made.
- We want to recognise where we need to improve.
- We want evidence to influence how improvements can be made.
- We want our own managers and staff to "know ourselves" and contribute to improving services.
- We want to make changes where needed – but the right ones.
- We want to develop systems and processes that are fit for purpose.
- We want to improve our response and communication with others.
- We want to "close the loop" around quality assurance activities to make a positive impact.

1.2 How have we tried to do this?

We have undertaken and continue to undertake a range of different activities drawing on aspects of quality assurance to support our arrangements; refreshing guidance, re-visiting policies and procedures, looking at how we consult and use learning from what our families say about us, considering how we write about children's journeys with us, re-visiting the language we use and using research and evidence of best practice approaches, to make changes that we need to. (Please see Appendix 2 – example of a letter to a child).

We have used our performance data to identify and highlight issues, which has then resulted in specific audit work to increase understanding and provide learning, to take action with a view to making improvements. The range of quality assurance activity undertaken during 2022-2023 has included:

- Practice evaluations (audits) undertaken directly with staff wherever possible to provide the rich narrative that is so important.

- Audit activity to improve specific performance issues identified at regular performance meetings and through data analysis.
- Regular service audit activity.
- Feedback from consultation with children, young people, parents and carers.
- Feedback from staff via consultation events, drop ins, deskside discussions, health check surveys.
- Providing learning and feedback about what we have found via newsletters, staff briefings, workshops and conferences.
- Communications by our executive director and director.
- Workshops for auditors to support improving consistency of audit activity and making audits more meaningful for workers.
- Discussing complaint themes and looking at how we can use the learning to reduce these.
- Linking with other LAs to consider whether we can learn from their good practice.
- Involvement in peer review mechanisms where we share initiatives and hear about other's good practice.
- Reviewing other LA Ofsted reports to learn about other good and outstanding practice.
- Reviewing the panels where we monitor elements of practice to ensure a robust approach.
- Organised external audit activity to assure ourselves that others perceive our service as we do.

1.3 Progress of planned activity from 2021-2022

We have used learning from different activities undertaken on a regular basis to feed into quality assurance discussions, using observations and evaluations from panels, collating Adoption Panel Advisor feedback and using an audit tool for CPRs to consider quality.

We sought views of young people about leaflets and templates.

We wanted to ensure that we cover wider consultation, and now have the parental partnership group, which is going from strength to strength. Service delivery managers provide feedback at Quality Assurance meetings about what they had seen in terms of quality of practice from audits received relating to their own services. This has now been extended to service delivery managers moderating Practice Evaluations.

We wanted to ensure that we used learning from quality assurance activity and enhance the "closing of the loop" and have worked to achieve this by incorporating learning into staff briefings, team meetings, training opportunities and updated guidance.

The QA Lead and Principal Social Worker (PSW) have continued to collaborate closely to identify training and learning events, holding workshops, and leading on the production of documents/strategies.

With the addition of a QA role for permanence, with a focus on adoption, we have created a Best Practice for Adoption Group and are working to share good practice around lifelong links and family first, collaborating closely with our T4C Regional Adoption Agency (RAA).

We have continued to have an element of external scrutiny of our audit activity to ensure that this is meaningful both for staff, but also to assure ourselves of the quality of the activity to highlight areas of both strength and challenge across our services.

QUALITY ASSURANCE ACTIVITY IN YEAR

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We have undertaken a range of audit activity in year including our overarching practice evaluations, audits focusing on the fostering service, family safeguarding audits, a range of themed audits, both identified by individual services and those identified from performance and wider discussions with managers and practitioners.

We have met regularly as a Quality Assurance Group, chaired by the director, ensuring that quality assurance discussions have been held to highlight learning and consider any actions and changes that were needed to make improvements. We have discussed dip sampling that service delivery managers have undertaken within their own service areas and talked about ways to improve getting the learning "out there" to staff and how best this can be achieved. We have included as a standing agenda item, service delivery managers feeding back about the practice evaluations provided on cases in their areas – to talk about what they have said in terms of the quality of practice but also about what the quality of the practice evaluations being returned has been.

The PSW and SDM representatives for children's services at Partnership Board pulled together findings from rapid reviews held, shared the findings with the QA Group and held events for managers and practitioners to share the findings and themes and drew together feedback to aid learning. This led to additional audit activity, for example, unborn babies, summarised below and actions to improve. This evidences the link between partnership activity and closing the loop with practice development and disseminating learning to enable practitioners to be aware of and engage with partnership findings.

We have considered feedback from a variety of consultative activities, including complaints and compliments, feedback gathered from children's consultation forms, foster home review feedback, panel evaluations, feedback from parents and carers, surveys, and feedback from staff. We have used this learning to influence change. We have also recently repeated the Bright Spot survey for looked after children and have undertaken other surveys such as a recent fostering survey (findings yet to be shared). We have also contacted parents, carers, and young people to ask them what they think about our involvement with them.

We have re-visited our practice evaluation tools, separating children in need/child protection, cared for children and care leavers. We have held further workshops for auditors and re-visited guidance to support them. New managers meet with the quality assurance lead as part of their induction to discuss quality assurance mechanisms.

We have continued to have external support to undertake some audit activity on our behalf to assure ourselves that our own findings were not out of kilter with what others felt. We have continued to moderate a proportion of our audits and have recently developed this to gain service delivery manager moderation of the practice evaluation audits returned to their own service areas.

Senior Management involvement in Quality Assurance Activity

Jo Britton, the Executive Director has met with teams throughout the year to hear their feedback about how things have been. Jo, together with the Director, Darren Knibbs, have held consultation sessions and drop ins with staff to enhance communication and consider learning and improvement plans. The Chief Executive holds "ask me anything" sessions with staff. He, along with the Cabinet Member for Children, Young People, Education and Lifelong Learning attend events such as Practice Week and Staff Briefings.

We continued to involve the Chief Executive, Executive Director of Children and Family Services

and the Lead Member in our QA activity. This provides our senior leaders with far more insight about the work social workers do on a day-to-day basis and about the quality of that work. It also enables staff to get to know our senior managers more informally when they spend time looking at a particular case alongside them. The Chief Executive also attends our Performance Board where he has the opportunity to challenge, seek more information and request additional activity to support learning.

Our recent development has been for senior managers, including the Chief Executive, to have "deskside discussions" with staff across services, a more informal approach where practitioners can talk about what work they are proud of, direct work with children and what the challenges are for them. This has been received exceptionally positively both by the managers and by the practitioners. (Appendix 1 provides an example).

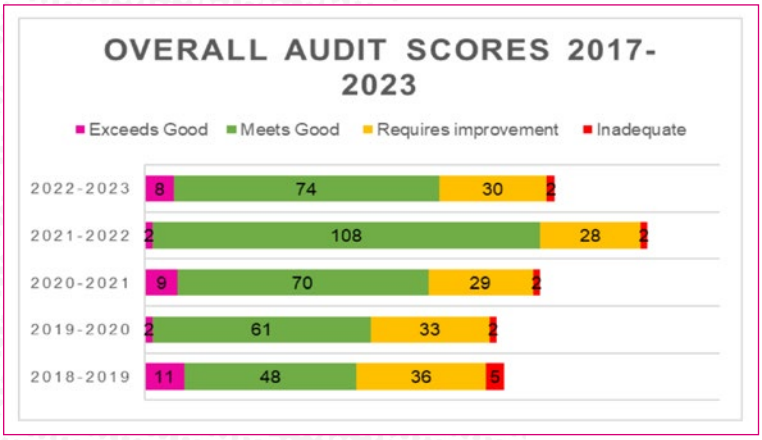
2.1 Audit activity and what we did as a result

Overarching Practice evaluations undertaken and what the findings were

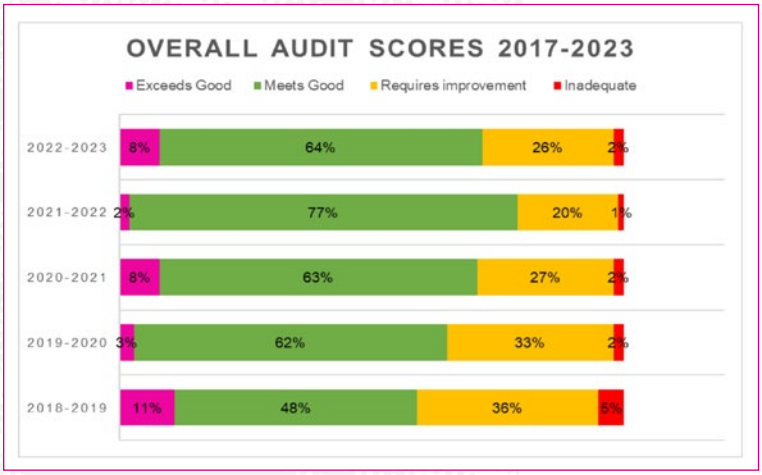
We have continued to undertake practice evaluations with staff involving team managers and Independent Conference and Reviewing Officers. This gives the opportunity for the auditors and workers to discuss the journeys of children in a more comprehensive way, reflecting on areas of learning and good practice.

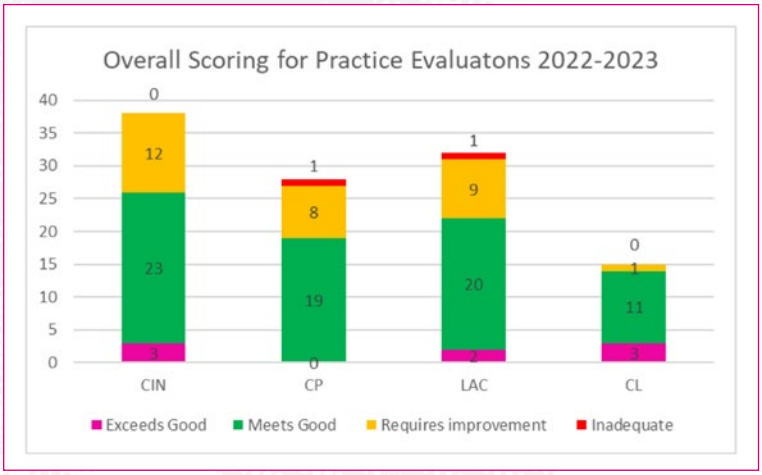
During 2022-2023 we completed the following numbers of practice evaluations during the overarching audit sequence.

- 32 Looked After Children.
- 28 Child Protection.
- 38 Children in Need.
- 16 Care Leavers.



To look at these scores as percentages please see below:





2.2 Main themes identified

Whilst overall scoring hasn't shown an increase of good and exceeds good in year, previous feedback has suggested that we have been "over optimistic", and we feel that the scores are reflecting more consistency of approach by auditors.

Individual scoring has reflected an improvement in the quality of assessments, which is positive to see.

Collaboration between agencies scoring has remained high, mirroring previous year with the majority scoring good or exceeds good.

Strengthening Families' involvement continues to be seen as positive overall, again with the majority scoring good or exceeds good.

Management oversight remains an area of improvement, although the focus of the auditors is noted to be around case supervision recording, which is only one element of management oversight overall.

IRO challenge and scrutiny has remained positive throughout the year, although more can be recorded to evidence challenge.

The child being at the centre has not scored quite as well as it has previously when this has been seen as a real strength, with the main reasons noted as being a lack of focus about the individual child where there is a sibling group, and for a small number where babies and young children are involved, not providing detail in recordings about reflections of interactions, bonding, presentation and development etc., and noting "too young to express wishes and feelings". Whilst not always reflected as well as it could be within recordings, practitioners are more than able to bring the child to life when spoken to, which is a really positive factor and recently praised within the SEND Ofsted Inspection. We are aware that recordings need to better evidence this area and have this as a current focus of work.

The practice evaluations do give a good sense of the child or young person and why we are involved as a service. Wherever possible auditors sit with practitioners and feedback is extremely positive about how they know the children well and hear about the positive work that they do with them. This is less evident where time hasn't allowed for undertaking the activity together and we continue to promote this as a joint activity.

2.3 Activity to "close the loop"

The opportunities for managers to comment at the point of authorisation of work has been further extended for additional quality assurance and to evidence management oversight more clearly. Managers can comment and return documents for further clarification/amendments/additions. A recent audit was undertaken regarding the themes arising out of the reasons managers had returned C&F assessments and a meeting then held with the team managers to discuss how the themes could be addressed to result in improvements. These were shared at a recent away day for the service and there will be a follow up audit to identify whether an improvement has resulted.

We have provided additional training and workshops throughout the year, using the learning from audit activity, for example regular family safeguarding workbook sessions, chronology workshops, genogram workshops, language sessions, CPR good practice presentations. The Principal Social Worker (PSW) leads workshops jointly with the system training staff to link aspects of recording and practice together and this has proved helpful for staff. The PSW provides a range of training and support to promote good practice, sharing research and presenting innovative approaches to support practitioners in their work. (The PSW has received positive feedback from the What Works Centre in relation to her application of research to practice).

The PSW has engaged with staff throughout the year to support improvements, shares links to research, webinars etc., and has provided good practice examples and drafted practice documents such as a life journey practice guide. The PSW has

worked closely with the QA Lead and together have produced the new Practice Framework and have also collaborated with others to lead on an updated Permanence Strategy "Family First" (in the process of being launched, alongside our Family First Conference).

The systemic team, led by the PSW, are supporting practitioners to implement creative and dynamic pieces of work with families. Quality Assurance activity has driven the direction of some of this work, for example, looking to improve placement stability by offering therapeutic family work. To enhance reflective supervision, the systemic team have also delivered training for senior social workers, to offer a space for reflection and to support their practice going forward.

To support good practice identified as part of quality assurance work of writing to the child, a working group is in place to support practitioners to do this and to put guidance in place as to when this is appropriate.

Service delivery managers and team managers have fed back learning from quality assurance activity to team meetings and at service staff briefings. Where practice evaluations have highlighted issues, managers have undertaken further audit activity and introduced wider learning from this in away day activities. An example of this was following completion of a practice evaluation earlier in the year which highlighted issues in relation to a CP case where domestic abuse was the main factor and the response was to proceed to ICPC rather than the exploration of the Family Safeguarding model, this led the manager adding an agenda item for the Duty and Assessment Development Day, to hear from the Domestic Abuse Practitioners and gain a better understanding of domestic abuse based on language and engagement that promotes the best outcomes for children.

We have updated guidance where this has been identified as needing additional clarity. We are in the early stages of creating an improved resource bank to provide training and learning tools and materials for practitioners.

We have developed monthly performance reports, written by the service delivery managers for each of their services to share what is going well, what the challenges are, what performance is looking like, what budget and staffing issues there are, what there is to celebrate and what quality assurance activity has been undertaken or planned. Team Manager updates will be incorporated into these, which will then be shared with the Director, who will in turn provide highlights for the Executive Director in our Performance Board.

The Parent Partnership will be instrumental going forward to provide practitioners, senior leaders, and partners with feedback from their own experiences of services, and how we can work together to bring about change. The wisdom from their experiences has already aided the re-shaping of our services and created a shared vision for our implementation of Family Safeguarding. The next phase of this journey is for the group to be trained in peer advocacy to support other parents to voice their views to shape their family's plan at initial conference, in addition to ongoing work supporting the training and development of our practitioners.

Our Quality Assurance post for permanence and adoption, together with our Permanence Co-ordinator have supported improved quality of CPRs, supported the production of an adoption journey flow chart and attended team meetings and service briefings sharing good practice. This links to the production of our Family First Permanence Strategy, promoting "family first" for permanence and life-long links. Our Best Practice for Adoption Group has created improved collaboration between our Together 4 Children regional adoption agency colleagues to improve good practice where adoption is the plan.

Midway review points have been developed for Chairs of conference/IROs to monitor progress of plans and templates are being added to the recording system. An away day is also planned for July for this team where there will be some discussion about a consistent approach to recording to improve their overall footprint.

2.4 Themed audit activity undertaken

Summaries of examples of some of our themed and dip sample activity undertaken in year can be seen below.

Re-plans within 12 months of de-planning 2021-2022

The predominant feature of the small number made subject to a CP Plan within twelve months of being de-planned was around domestic abuse and highlighted the issue of relationships which we had understood as having ended, but had not been the case subsequently, with couples resuming relationships. Drugs and alcohol were also a feature for the majority as was neglect, which was also linked to the former in some situations. Mental Health issues were evident for two of the cases and sexual abuse also evident for two. There was also an element in more than one situation where during our involvement acceptable standards within the home had been improved and maintained but once we were no longer involved these had once again deteriorated.

As Family Safeguarding continues to be embedded as a model, learning is being shared about domestic abuse and how this can be approached differently. Feedback from families indicates that our Adult Practitioners are having a positive impact to achieve change. A Home Conditions Tool has been incorporated for Strengthening Families and shared with Partners to achieve a consistent approach and to provide a measure that can be shared with parents – this is being rolled out across services. 2022-2023 has shown a sharp decrease of re-plans within twelve months, which is positive to see.

PRH Referrals (referrals from the Princess Royal hospital following a CQC Audit)

A lot of work had already been undertaken in respect of referrals from the hospital following an audit by CQC, looking at the quality of referrals coming in. This audit was to look at a selection of referrals received in Family Connect. (A new template had been created already).

Areas of good practice

- Consent was clear when obtained, context was provided by hospital if consent was not obtained.
- In the main ethnicity was recorded by PRH within RFSF.
- 80% of RFSF were typed, this is a significant increase from previous audits and ensures information is able to be clearly read and understood.
- No delay was identified in information being shared with Family Connect from Princess Royal Hospital.

Areas of development

- One example, consent was not obtained, and rationale provided was not in line with safeguarding procedures.
- Family demographics not completed in full, blank on some and dates of birth missing. Religion was consistently missing on RFSF's.
- 60% of RFSF had no overview of health needs of YP. Focus was on what the individual had done, and the action taken place by A&E, such as referral to BeeU (Children and Families Emotional Health and Well-being Service). BeeU overview and assessment not included within RFSF.
- 60% of cases, context was not provided around why the child/parent had harmed themselves or been harmed and had presented at PRH. It is noted that 20% of the reason why was due to barriers experienced by A&E, such as Parental MH and police involvement.

Meeting to be held with Teresa Tanner, Lead Nurse for Safeguarding Children and Young People, around QA audit findings and a discussion around content within RFSF to agree a standard approach when these are being completed, e.g., reason and build up to attending hospital, pattern of health concern, and overview health support for child at point of discharge and holistic needs of child and their parent/carers.

Pre-birth Audit

It was identified within a rapid review that the regional child protection procedures were not followed as there was no pre-birth assessment completed, whereby the older sibling was subject of a child protection plan. As a result of this we wanted to assure ourselves and the national panel that this is an isolated situation and not a systemic issue. To provide this assurance, we examined cases of thirteen unborn babies who had siblings subject of a child protection plan.

Learning

- C and F can be brief – need to ensure the impact of a new baby on the household including the competing needs of the children is made clear in addition to the ability of the parents to meet the needs of the unborn. Rather than relying on the concerns in respect of the older children in their entirety.
- Unborn children being made subject of plans prior to birth rather than following.
- Where progress has been made for older children, this is without the demands of the younger child, and this being assessed – therefore this to be evaluated prior to de-plan.
- Ensuring the same threshold is applied for both children.
- Whereby a family transfers from another area we ensure the C and F assessment reflects our assessment of the current circumstances as well as the history.

Children placed at home with parents, subject of a Care Order

The audit was undertaken to look at current practice and how effective the Local Authority is in progressing the discharge of care orders for children placed with parents.

Areas of good practice

- Involvement is making a positive difference.
- SWs know their cases well.
- Regular supervision.
- Where safeguarding concerns have been identified, they have been acted on swiftly.
- Reviews are held within timescale.

Areas of development

- Regular IRO oversight of Children Placed with Parents Report.
- All Children placed with parents should have a clear plan for revocation in the initial report.
- IROs oversight to review plans to revoke. The CIC review's purpose is to ensure that the local authorities (LA) plan to revoke the order is progressing.
- Focus on what does good enough care look like? Safe uncertainty.
- IROs to have more direct contact with children.
- Effective use of IRO rag rating.

Actions

Increased monitoring of this cohort of children going forward:

- Midway Reviews for IROs to be added to the recording system.
- Flow chart of activity to be circulated.
- Permanence to identify timescale to commence revocation documentation.

Private Law

The pathway was amended following work completed by previous CPFS SDM with the intention of ensuring a robust mechanism for challenge of inappropriate requests from Court for Section 7 reports where CAFCASS should be writing reports as well as increasing visibility for workflow when matters received into Legal services, referred into Family Connect and then transferred into Family Safeguarding (previously CPFS).

Areas of good practice

- Once aware of the Court Order, it was evident within the IKEN (recording) system that T&W Legal Services chased outstanding information daily.

- 3 of the 4 file audits had the Court Bundle uploaded within the workflow. 1 case that did not have the Court Bundle uploaded was already a child subject to a CIN Plan and well known to the Local Authority.
- Once Family Connect became aware of the Private Law Court Order, information was chased and progressed timely resulting in no significant delay to FS Teams being notified.

Areas of development/actions

- File evidenced delay of timely allocation of S7/S37 to a Social Worker when transferred to FS Teams without context or management oversight recorded. This resulted in a Court extension being requested.
- Management oversight in respect of S7/S37 to be strengthened around key decisions such as delay in allocation, clear management direction in respect of case progression and including regular case supervision being recorded.
- 1 file evidenced a 4-week delay of the Court notifying T&W Legal Services of the Court Order.
- To ensure that all key documentation such as extension requests and new Court Orders are uploaded onto the child's record.
- Clarity to be provided to all Social Workers and team managers where case notes should be recorded on the child's file when a Legal workspace is open.

Family Solutions Audit on management oversight.

Areas of good practice

- Supervisions are holistic.
- Supervision takes into account systemic practice and thinking/hypothesis.
- Direction is clear.
- The changing needs of the family are taken into account.
- Positive progress is recorded.
- Timescales for supervision are generally met.
- Timescales for support plans are generally met.

Areas of development

- On occasion case supervision is going out of timescale.
- Allocation discussions are sometimes not well recorded.

Discussion within the team to take the learning forward.

CPR Audit (practice to use CPR audit tool commenced 2022 for team managers to quality assure CPRs for authorisation). This audit was to review outcomes from the audit tools completed.

It is assumed that the sections that covered child's experience in foster care, contact, assessments of family, key decisions, support analysis and reasons for adoption over other orders were satisfactory as there were very few comments asking for amendments to these sections.

Findings

- Genogram information gaps.
- More observations of care to be provided to chronology.
- Child's section would benefit from further information – routines, likes and dislikes, personality, identity.
- Gaps in medical information/medical report being added.
- Gaps in family history.

Actions

- Continued audit of CPRs.
- Service Briefing agenda item and discussion.
- RAA CPR workshops planned with T4C.

Feedback at a recent Best Practice for Adoption from the Panel Advisor was –

- Telford social workers are very responsive which is helpful.
- Very rarely the advisor has to chase social workers for CPR when a child is coming through with a plan of adoption.
- Telford CPRs beginning to show more individual information in the first section about the child's personality, likes and dislikes, giving a good sense of that child.
- Impressed by some social workers who are newly allocated to long and complex proceedings who have made a real effort to go and meet those children and the CPR is reflective of that.

CSE audit

This was the first the audit of this nature since the multiagency risk panel was separated into CSE and CE categories. 8 audits were completed, each agency completed their own audit tool for each assessment. Agencies involved were CE Police Team, Youth Justice, 0-19 health representative, BEEU, Sexual Health, Virtual Schools, Public Health Practitioner, Named Nurse for Safeguarding Children and Young People.

The main areas of good practice referred to the assessments having a clear plan with all of the relevant agencies contributing to the plan. The plans were specific to the child's needs and had timescales incorporated clearly.

It highlighted good evidence of relationship base practice and hearing the child's voice throughout the assessment process.

The audits highlighted that health needs were identified, and that appropriate support was in place to meet health needs and that Education needs were addressed with the support from Virtual schools.

The assessments identified that National Referral Mechanism (NRMs) are considered and applied for where appropriate. The information could have been more detailed.

Areas of good practice

- The Young Person was recognised as a victim of exploitation and language used reflected this as non-victim blaming.
- Clear Plans, specific to the needs of the young person, appropriate agencies involved, clear timescales and young person, parents involved in the plan.
- Good evidence of relationship-based practice, Practitioners knew their young people well in most cases.
- Voice of the Young Person being heard, this was referenced to in respect of the interactions with the CATE Practitioner as well as School nurse, police and education.
- Health, assessments referenced general health needs, emotional health needs and sexual health needs. Identified Trauma and childhood aces.
- Education, assessments gave a good overview of educational needs, alternative provisions and the involvement of Virtual schools to support when needed.
- Disruption, whilst it was recognised that disruption was referenced within the assessments and plans, it was also recognised that the information could have been more detailed.

Areas of development

- Plans to be reviewed and updated once actions have been achieved/completed.
- More evidence in the assessment that work has been completed with parents to raise their awareness of exploitation.
- Analysis, this was an area that had varied comments depending upon who had completed the assessment. Work to be completed with the team to ensure that they understand what a good analysis looks like, how to write one and how to pick up the salient points to complete an analysis.

- Whilst the audit highlighted NRM's were consistently considered in the assessment, which was a positive, further training has been identified for the CATE Team and Police to attend with the SCA to further enhance practice, learning and understanding of the NRM process and the benefits that the NRM can give.
- The recording of disruption is an area that is difficult to record fully due to the sensitivity of the information and on-going police operations. CATE team managers and CE Police Sergeants to review how this could be improved without jeopardising any police investigations.

Actions

To share examples of assessments that have been highlighted as good quality assessments at the next CATE Team Meeting and discuss what makes a good assessment.

Through case supervision all Plans will be reviewed to ensure Practitioners are updating them on a regular basis to ensure they are current and relate to the current concerns.

To complete a session with the CATE Team in respect of how to incorporate parent's views, perspectives and understanding of Exploitation into the assessment that they are completing.
To complete a session with the CATE Team in respect of how to write a clear analysis at the end of their assessment.

CATE Practitioner to complete a joint visit with CE Police to the SCA to further enhance practice, learning and understanding of the NRM process and the benefits that the NRM can give, this can then be cascaded throughout the team.

CATE team managers and CE Police Sergeants to review the recording of disruption and how this could be improved without jeopardising any police investigations.

Audit to be repeated to review if learning from the recommendations and actions identified have been progressed and had the desired impact.

Well-being supervision Audit

Personal supervision completed by FS team managers over the past six months. This has focused particularly on our 21-22 cohort of ASYE's who have completed final placements and portions of their ASYE during COVID. It is also a follow up audit following an earlier one which focused on the same issue in August 2021.

Responses were received from team managers of FS 1-FS 3, this evidenced that well-being supervision took place monthly which was positive. There were some gaps from FS Team 1 which reflected the absence of the Team Manager during the year.

Previous audit highlighted inconsistency of completion of well-being supervision within Family Safeguarding, however, this audit has highlighted that this is occurring on a regular basis.

Key learning from this audit was that we need to develop contingency planning when team managers are absent from work to ensure that Social Workers receive the support they require. Individual work to be completed with Team Manager who did not return information to reflect on quality of supervision with their Social Workers.

Family Safeguarding

Auditing is in place for the Family Safeguarding model, with group supervision and worker summaries undertaken as themed audits regularly. The practice evaluation tool also covers the FS workbook activity.

Group supervision – dip sample

Areas of good practice

- The use of motivational interviewing is evident overall.
- The voice and lived experience of the child is captured.
- Group supervision is signed off in a timely way.

Areas of development

- More timely group supervisions.
- Workbook summary completion in timescale.

Family Safeguarding worker summaries – dip sample

Areas of good practice

- Evidence of the child's lived experience being explored.
- The voice of the parent is clear about their views of what needs to change.

Areas of development

- Summaries need to be more detailed, and capture wishes and feeling of children and young people better.
- Summaries need to have clear links to actions identified within the current plan.
- Improved recording of work undertaken on visits.

Actions

- Group manager creating good practice guide.
- Improved tracking of progress of the workbook.
- Findings to be shared with team managers.
- Individual discussions to discuss gaps.
- Continue regular workbook refresher training with PSW/system support.

CIN Audit

Audited were children who had been on a CIN plan for 18 months or longer and a total of eleven families were identified.

SDM reviewed data and focussed on C&YP who remain open to Family Safeguarding. Focus was on last CiN plan and whether this was in timescale and of good quality. At time of writing, SDM was of the view that it was appropriate for nine out of the eleven families to continue to have support given the complexity. One needed to be closed as the young person had recently reached the age of eighteen and another identified for closure following a C&F assessment being completed.

There were positives noted around plans; these were of good quality and reflective of work being completed by Social Workers.

However, key learning identified that social workers need to ensure that plans are consistently being updated as per agreed timescales. All plans in respect of siblings need to consider individual needs of each children. In addition, team managers should ensure that they are consistently adding management oversight/footprint both in terms of review/progress of plan or agreed timescales for out of date work.

SDM used his weekly management meeting to discuss findings and to progress actions identified.

Care Plans Dip Sample

Findings

The care plans were up to date and were clear as to why the request for becoming looked after was requested.

Child C had a comprehensive background, but the impact of this on the child could have been clearer.

All but one plan included contingency plans.

All plans showed that we can see what is going well for the child however child C states "direct work but not an overview of the child's views."

Child A – we could see the child/young person within the planning and their views are clearly recorded in the plan. Child D had included this however it was noted "that trying to write care plans directly to the child could increase their visibility." Auditors for Child B and C noted that visibility of the Child/ Young person well within the planning was not as clear as it could be. For Child B it was noted it would "be helpful to separate out individual needs as they become known." However, the child's views could be seen through observations.

All but Child C's plan included the parents/carers views as well as being written in family friendly language.

It was good to see that all plans had a scheduled date for the next care planning meeting, however, Child A was dated September and this update was still incomplete and in draft at the time of writing.

Findings were shared across teams and there will be a repeat audit in six months to identify impact of the learning.

CP Plans with category of Neglect

The audit included looking at historical involvement, those where children had been subject to CP Plans previously, SDM oversight, Core Group activity, IRO footprint, whether pre-proceedings had been considered, whether the CP Plan was progressing and the CP Planning.

Areas of development

- CP Plan content be SMART and updated in a timely way.
- Discussion with SDM prior to repeat ICPC to consider actions.
- Evidence of SDM oversight at 6 months.
- Oversight of regular core group activity.
- Chair contact with families and evidence of footprint.
- Chronologies to clearly identify historical involvement.

Recommendations

- SDM to review individual cases identified.
- Training on CP Plans.
- More work around language used.
- Young people to be spoken to about the CP process and what it means for them.
- Improved oversight of core group activity.
- All requests for conference where this would be a potential re-plan to be discussed with SDM.

Cases presented for ICPCs – dip sample.

Areas of good practice

- Threshold agreed in 9/10.
- Chairs meeting with parents and separately with SW prior to the conference.
- The correct category is identified.
- Where children or young people are not present their lived experience is shared by professionals.

Areas of development/actions

- Contingency plans to be tailored to each child and family.
- Timescales for tasks set need to be relevant to the child's need.
- Consider how children and young people can be included in some or all the meeting.
- Include Chairs entry in child's record.
- Chair to speak to SW prior to ICPC/RCPC.
- Chair should discuss with SQAS TM if threshold appears to be not met.

Three Plus Placements

Findings

- 31 young people have been aged 12 plus, a number where there have been some complex behaviours and an extensive history (13 who have been looked after for three or more years).
- There have been situations where children have been placed with relatives which have not been able to continue, but also six have been able to move to a relative, and eight have been able to return to a carer had already been with.
- Several placements necessitated temporary/ bridging arrangements, some where the young person could not return to their original placement. This has been more prevalent than in previous years.
- Frequency of care planning meetings not consistent.
- 15 of the children with three or more placements became looked after in the current year.
- Ten young people moved from a long-term fostering placement.

- Placement Support and Stability Meetings not routinely held.
- The majority had at least one change of placement review.
- PLRM (disruption meetings) – not routinely held.
- Positive that some children have been able to return to the same carer that they had previously.
- Positive that some children have been able to be placed with family members.
- A small number of older teenagers have requested to move to semi-independent placements.

Recommendations

- Re-visit arrangements for Placement Support and Placement Stability meetings.
- Re-visit recording arrangements for Placement Support/Placement Stability Meetings.
- Improve timeliness of Care Planning Meetings.
- Review arrangements for recording Placement Planning Meetings.
- Review arrangements for IRO direct contact/ meeting with children and young people.

Child Protection Audit Activity

Child protection numbers spiked during the year and a deep dive audit was undertaken to ensure that we are not involved in the lives of families under child protection procedures where it has not been identified that children are at risk of or are suffering significant harm. This also followed the launch of the re-fresh of our threshold document.

Areas of good practice

- Good quality case summaries.
- Frequency and quality of visits to children.
- Regular core groups overall.
- The actions have been and are being undertaken.
- Some positive management and Chair oversight, but not across the board.

Areas of development

- Workbooks not being progressed in a timely way.
- A small number where visits were outstanding (later identified as recording in the main).
- Some core group notes in draft.
- Lack of escalation.
- Delays due to waiting lists resulting in continued plans as opposed to continued significant risk of harm (not always clear about impact on the child).
- Conference notes with insufficient detail re evidence and rationale.
- Significant harm not evident in all cases.

Actions

- Workbook review points to be identified.
- Robust monitoring of longer-term CP Plans (6 month onwards).
- Systemic Discussions considered at three and six months.
- Core Group template changes agreed.
- Meeting to share finding with Chairs of conference.
- Individual case records to be reviewed where identified.
- Partnership to be approached re training for partner agencies re core groups and CIN Plans.
- Team away day for Chairs of Conference.
- Repeat audit in three to four months.

Cared for Children's Plans

In total 27 plans were reviewed; these were a combination of S20, children in proceedings and children subject to Care/Placement Orders. Previous audits in the service have focussed on CP/CiN plans and the decision to look at cared for children is to ensure consistency in the service.

Findings

Over two thirds of plans reviewed were RAG rated as Amber/Green (20) which is positive. Furthermore, the vast majority of plans were in timescale, only one in draft which wasn't reviewed and one that requires update as a matter of urgency. Where plans were seen to be Good, they contained detail, which

supported the readers understanding of the current circumstances; actions were clear and SMART and were linked to individuals in sibling groups.

Areas of development

- Some plans lacked detail, with actions being too vague.
- The current situation was not always clear with the plan.
- One care plan didn't take into account the identified needs of the child and how these would be met.

Actions

- Specific plans to be updated.
- Review of audit discussed within management team.
- Repeat of audit in six months.

C&F Assessments

The C&F audit was completed March 2023 – all assessments had been completed in the month. The rationale for this sequence:

- Current practice.
- Impact of Manager first line QA/authorisation themes identified in earlier audit.

The audit followed a review of when team managers had sought more information at the point when they were providing management oversight at the end of C&Fs, where they have the opportunity to return the C&F to the work as part of QA.

Themes previously identified when returning C&Fs:

- Fact and opinion not always clear.
- Use of language.
- Dates not always there – losing sense of context.
- Not being proofread – rushed recording.
- 1 dominant sibling within a sibling group (focus of assessment for individual child).
- Copying and pasting history and referral detail into referral.

Findings

Overall, the C&Fs were of good quality, and it was pleasing to note that assessments undertaken were proportionate to the circumstances requiring assessment. It would have enhanced the record when completing a proportionate assessment if this was made clear along with the rationale as to why this is the case.

Good practice

- Clear ability to communicate with children and their families and form working relationships immediately.
- Some good evidence of direct work with children having been undertaken and the tools used.
- Good liaison with key professionals.
- Good judgement in regard to when appropriate assessment is required.
- Some good evidence of cultural awareness and impact on child and parenting.
- Most assessments clearly written.
- Some good attempts to write the assessment to the child.
- Voice of child and parent included in assessment.
- Clear risk assessment built into the assessment identifying needs, strengths, impact for the child and support planning.

Areas for development

- There were some examples of very good concise explanations as to the purpose of the assessment and clear recording of the analysis of key events and previous history for the family and how this impacts upon the current family situation (strengths as well as needs) However, this was not found to be the case in all of assessments that were audited. This is an area for development.
- Lack evidence of research informing assessments.
- Use of language when writing the assessments.
- Too much descriptive recording – it would enhance the assessment if analysis was threaded throughout the assessment report.

Action

CPFS Assessment Development Day arranged. Focus will be C&F assessments. Back to basic training – clarity of expectations to gain consistency and to use the good practice and learning found within this audit to improve and enhance assessment practice. A service plan to be developed following this.

2.5 MACFA

A Multi-Agency Case File Audit (MACFA) was held on 25 January 2023, reviewing three cases where young people had multiple presentations to A&E in mental health crisis. The aim was to identify points in the child's journey where agencies could have intervened or offered support, to prevent the child from reaching crisis point.

Case 1

Recommendation: To explore the possibility of a multi-disciplinary team – similar to that of the Family Safeguarding Model – to support children's emotional health and wellbeing alongside social care, Strengthening Families and health, for example. It is recommended that an analyst review the numbers of children and young people who may benefit from this proposal.

Case 2

Recommendation: Clear rationale to be detailed and evidenced for finishing a Child Protection or Child in Need plan. All aspects of the child's wellbeing need to be taken into consideration when discussing their case at a conference, including, but not limited to, physical health, emotional health and wellbeing and social care needs, prior to determining whether the level of support for a child or family should change.

Case 3

Recommendation: To introduce a robust transition method to support young people moving from child to adult services between the ages of 16 to 18 years of age. This will aim to ensure that young people are equipped with the tools and strategies that they need to support themselves, as the adult care support offer is very different to what they would have experienced as a child.

Key messages

- There is evidence of strong multi-agency safeguarding work between partners in Telford. It is key to consider a child's presenting needs collectively and develop a multi-agency plan to support the child in all aspects, rather than on an individual basis, and use this to inform decision-making in relation to stepping up or down with care plans.
- It is crucial that practitioners from all agencies who work with children, young people and their families have an understanding of children's mental health, to enable the child to access the right support at the right time.
- Considers the development of a multi-disciplinary team which encompasses mental health support for children and young people, alongside social care and other services.

CONSULTATION

CONSULTATION

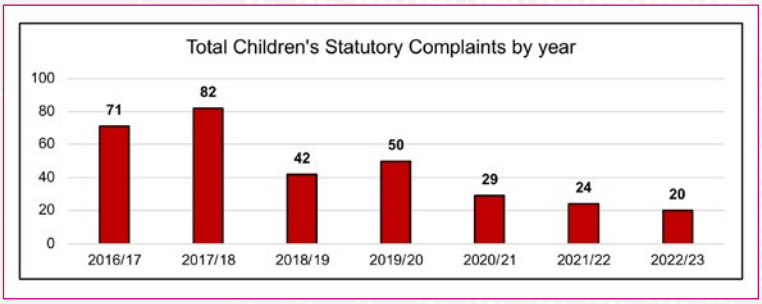
3.1 Complaints and Compliments

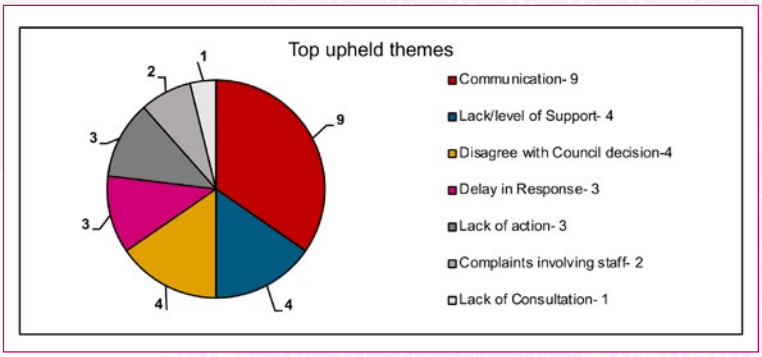
Highlights 2022/23

The lowest number of Children's Statutory Complaints received for the last eight years.

17% reduction in Children's Statutory Complaints.

The average number of days to respond to complaints is 16 days.





The complaints and quality officer attends our Quality Assurance Meetings on a quarterly basis and provides feedback about the complaints received, the themes, the actions taken and learning to take forward. The officer tracks responses and actions that have been agreed as part of the complaint outcomes, whether that be direct discussion with individual workers or change in process.

The Quality Assurance group identified the following key themes to take forward in service learning:

- Communication (including the need for sensitivity).
- Clarification of roles and responsibilities.
- Involvement of parent, family and young person; recognising the value of the extended family and honouring them in the child's life.

During the year several managers from the service have attended Effective Complaints Handling workshops delivered by the Local Government and Social Care Ombudsman. There are plans to extend this offer next year and make improvements to local complaint handling.

In terms of sharing the learning the PSW shares learning with the Community of Practice Groups who, in turn, will discuss this in team meetings. We are also looking to collaborate with staff to better understand the impact of the issues raised in complaints, and why it is important to improve how we work with people, so as not to be in a position where they feel that a complaint is necessary. We have improved our direct contact with complainants, which has resulted in improved outcomes.

3.2 Examples of feedback/ compliments received

Examples of family feedback

From a grandparent

"S here, I did not know what to expect when we were going to meet you for the first time due to social workers having a bad name but from the first time, I met you we felt at ease with you, you were quietly spoken and very easy to be able to communicate with you. Without using any bribes or anything your manner really got E to communicate with you and to like you so much she asked us to get you some imperial mints as she knows that you like them. And for E to

take to a male like she has with you just shows that you have the right touch, and as for myself I appreciate everything you have done for my daughter all the help and advice and helping her sort things out when we didn't have a clue what to do you have restored my faith in the social system and I would like to wish you all the very, very, best in the future knowing that anyone you go to assist they will have the very best help and advice they can possibly have".

From a parent

"It has opened my eyes to things I couldn't see. Helps me to understand my children and given us a better relationship. Better communication maybe but other than that he is brilliant and overall happy with the service. Fully supported and appreciate the service".

From a parent

"I think when parents are trying to work hard to improve there should be more communication. Great for the children but better support for parents, but she is great and different than before".

From a parent

"N has been a massive help. She explains everything and is so patient. She has a great relationship with my daughter, and we will be so sad when we don't have contact with her anymore. Nothing is too much for her. Huge help. We wouldn't be where we are without her, if there could be an award, I would want her to have it. She is an amazing lady. Without social services the family would have been broken up. N has been amazing. Opened my eyes to the way I was acting. She even went above and beyond at Christmas for example getting presents for my daughter. Thank you so much keep up the good work."

From a parent

"We were at first upset that we had been referred but looking back we have realised how lucky we are to have this support. Since you have been involved you helped me with the PIP application, supported me and health visitor helped me get the perinatal support and it has been on the up ever since. So, thank you so much for helping me'."

From a parent

"I would like to express my gratefulness for the way that V has dealt with the situation regarding my son being in Telford. Since he left Ipswich to stay with his girlfriend early January, I have interacted with around different professionals with no change being made during this time. The case was finally passed to the Telford team less than a week ago, and I received a call from V from the family connect team. The call was extremely helpful, informative and V showed care and consideration when we spoke about what had happened. Something I do not think I have got during this time. Since then, she has spoken to my son and has updated me on all occasions, with useful information provided to all involved, to the point my son has agreed to come home on Sunday. This is something I have been wanting to happen for several weeks now. I wanted you to know how helpful and considerate your team member has made me feel at such a tough time, please pass on my sincere thanks, praise, and gratitude.

Feedback from children and young people

"Everything has changed for the better from the moment you came in, thank you for all the help."

"Thank you for all the help, I will miss you".

"She is very approachable. She gives me PA support and help to sort things. She reassured me during this time. Really love her way of working. She has a good duty of care. She picked me up and supported me. Helps with finances. I texted her when she was on leave, and she responded. She tells me how it is but in the best way".

"She has supported me and my family through tough times and was always there for us to talk to. She is truly a bright light in life as she never stopped believing that we will make it through! She recommended many methods to me during

the times I was hurting; healing, like self-help videos and podcasts."

"J has made a significant difference for me and my family through these rocky months. She has done this by making us feel supported and giving us a helping hand when things got difficult."

How do you get on with your social worker?
"Very, very, very, very, very, very, very well!"

Extracts from feedback about Family Safeguarding

N says that the FS model as changed her life, she has never received support before for her MH or alcohol use and feels this model as benefitted her immensely. After completing the parent programme with me, reducing her alcohol use completely and working with C to prepare her mentally for rehab for a twelve-week programme. She feels this came around at the right time for her and has changed her life.

"Whilst I still has a long way to go until I believe I'm where I should be in my life's journey, but I can tell you this, I am in a place mentally now that I never ever thought reachable and continue to discover more about myself and the world around me...thankyou x".

"I am writing to give my recommendations for the services and support I have received on a one-to-one basis with K from Stars, who I have found that the work we have completed together has been highly effective in my ongoing recovery. My thoughts on this service are a must for people that are wanting to change including myself. I would not be where I am right now without the support of this service and the work that we have completed together. The help, support, and advice I have received from K has been life changing. I cannot put into words how thankful I am. She never once judged me, and she gave me a safe space to talk and to be listened to. I would not have been able to do this journey without K by my side. She gave me a strength; I had forgotten I had. The work I have completed with her has helped me see things from a different perspective and taught me things I wouldn't have realised before. Everyone that has been in a similar situation to me needs someone like K. The work we have done has been invaluable to me. I am confident I will use the things I have learnt with her for the rest of my life. Life would be a whole lot different if I did not have this support. I will be forever grateful."

Wider feedback

Fostering Panel
"On behalf of Panel Members and myself, I would like to thank and compliment you for your presentation at Panel today, of the Form C Assessment for L - the Assessment was thorough, balanced with a high level of reflection and analysis. Your personal presentation in support of the Assessment was excellent and displayed a high level of detail and knowledge of the case, the applicant and family members and was very balanced. Panel members wished you to know that they considered the Assessment to be the best that we have seen and is particularly significant given the complexity and serious events surrounding the entire Case".

Family Court Adviser
A surprising conclusion to L's proceedings today, but a welcome one, nevertheless. I wanted to thank you on L's behalf for your focus and dedication to her as her Social Worker. Please do not ever lose the wonderful and caring approach you clearly have.

L's solicitor wrote to me earlier and said
"this social worker is such a breath of fresh air…" I hope you are enjoying social work and L has really benefitted from having someone like you in her corner."

CPR Quality
"The CPR has been well written. It is easy to follow and to understand. R may need to be supported to read it owing to the information within it, but she will have a good sense of assessments that were completed, why she

could not remain with her birth family and why she was placed for adoption. There is a well-rounded sense to the CPR in that R will have some understanding of her maternal and paternal families, as well as her siblings, which will be important to her."

Magistrate feedback

Some positive comments made by the Magistrates today in respects of M's SGO assessment for W, they stated it was a clear and concise assessment which captured a lovely picture of how well they are doing as a family!

Judge feedback

The judge made clear that the social worker's team manager should be informed about the quality social work that has been undertaken. He said: ***"You have done a first-rate job. If it wasn't for you, this child may not be in the family, and would likely be adopted. You have allowed this child to grow up in his family. Your manager must be told. Thank you"***

3.3 Examples of social worker feedback as part of QA activity

"Social worker feels very supported, talked about having a period of bereavement and was well supported through this time."

"I do not feel unsupported or undervalued".

"The worker felt that there 'is a good model here' and it supports practitioners".

The worker felt that her team 'bounce off each other and take on different tasks' and added that 'Telford is supportive,' compared to what she has experienced elsewhere."

"J feels that generally Telford & Wrekin offer a very good level of training, but he said it would be good to have some more detailed training about 'Neglect', he feels that often this concern is either identified too late in a child's life, or even when it is suspected it often proves hard to gain sufficient evidence to safeguard the child positively".

"Yes, Telford is good at offering training opportunities. Also, I get a lot of support from my manager and team where we all know a bit about everything so can support each other."
"Yes, absolutely, all the new starter training for new staff on Ollie and sign posted to additional learning opportunities."

3.4 Feedback from staff as part of the Staff Health Check 2022

Most staff preferred the flexible working arrangements as it allows for better work life balance. The downside was that not all the team are in the office at the same time.

For our annual practice week event - many felt that this was a good event but would prefer it to be face to face and hear more first-hand experiences. Sessions were requested to be recorded, to be accessed later for those that could not attend. Some felt that success was not communicated in an effective way.

There was mixed feedback from staff on how information is disseminated, some felt that it was difficult to find/hear information until too close to the date of an event. Tri-x system not very user friendly or intuitive.

Some felt that the inductions lacked consistency. Ollie training was not easy to manage.

It was suggested that staff felt the training being offered was relevant but found it difficult to allocate time to do the training due to workloads. It was fed back that some training is not applicable to specific roles and that there is a strong focus on Social Workers and no to other staff.

Actions planned to address the feedback.

We will consult with staff through the staff consultation group to develop what flexible working looks like in Children's Services – pros and cons of home working and office working and agree and articulate our offer.

Face to face sessions have been included for some but not all annual practice week sessions as feedback was variable. Content has also included a variety of lived experience speakers and workshops. Sessions will be recorded where speakers are in agreement for this to be the case - not all will allow for this due to copyright.

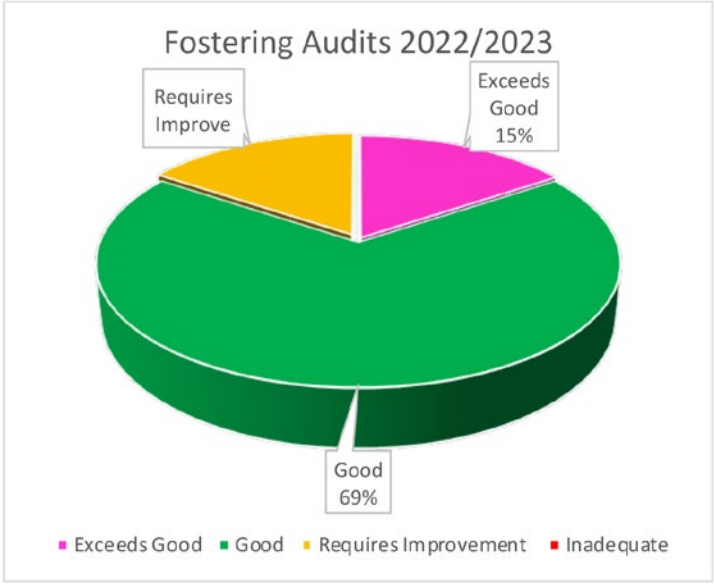
There will be new standardised induction guidance to drafted and shared for consultation at the SCG and workforce development plan will be consulted on giving all staff the opportunity to provide feedback.

A working group to be established to include frontline practitioners, to agree and review all content of Tri-X, as well as forward plan for sharing resources and policies, procedures, and practice guidance – to include comms. The ways in which we share information between staff will also be raised at consultation group. There will be a review and refresh of the OLLIE training offer for children's services.

Finally, managers to be asked to share successes in Jo's weekly newsletter. Managers to also recognise excellent work within team meetings and service meetings.

3.5 Fostering – annual overview of QA activity and auditing

Overall scores



Areas of good practice

- Foster carers have a good understanding of the foster children's cultural needs.
- Foster carers feel confident in managing the children's needs and supporting their development.
- Foster carers promote contact with birth family.
- Foster carers support children with life story work.
- Foster carers adapt to the needs of the children placed with them.
- Foster carers are proactive in meeting children with their cultural needs and seek support if needed.
- Foster Carers support children to pursue their individual interests and hobbies.
- Key information regarding the fostering households is kept up to date for the majority.
- Foster carers and members of the fostering households have up to date DBS checks and medical checks – processes are followed to ensure that these are updated when required.
- The majority of foster carer summaries are kept up to date. Case summaries are well written and provide a clear and accurate picture of the foster carers' circumstances.

- The majority of foster carers have a PDP in place – these are relevant and up to date and include target dates for training to be completed.
- PDP's support foster carers to attend training and highlight training that would be useful to carers.
- The majority of foster carers have completed TSD's; where this is outstanding for some there are plans in place for carers to complete it.
- The majority of foster carers attend regular training, and the completed courses are logged on their training record.
- There is evidence that training expectations are discussed with foster carers during supervision sessions.
- There is evidence that foster carers support needs are discussed during foster carer supervisions.
- Fostering social worker and children's social workers respond to foster carers support requests when required.
- Foster carers are allocated support workers/ therapists when needed.
- Some carers are part of the Mockingbird Programme and find this support useful.
- Fostering social workers support foster carers to attend support groups when required such as the Men who foster support group.
- Supervision discussions are child focussed, this is detailed for some, and auditors were able to gain an understanding about the care children are receiving and the challenges that foster carers face.
- Recordings provide a good picture of the home situation.
- Foster carers and fostering social workers attend CIC reviews.
- There is evidence that the foster carers have a good relationship with the child's social worker.
- Case notes on the foster carers record indicate that there are regular emails/conversations between the fostering social worker and children's social workers.

Areas of development:

- Foster carer summaries to be updated following placement changes.
- Key information needs to be clear who is living in the fostering household; this was not clear for some fostering households.
- Some foster carers struggle to attend face to face training courses due to work commitments.
- Not all foster carer training records are kept up to date.
- Lack of consistency for Placement Planning meetings
- Safer care document too generic and not specific to the child.
- Not all fostering social workers and children's social workers have a good working relationship. One fostering social worker experienced repeated issues with communicating with the child's social worker.
- Supervisions have not been held consistently. The supervisions are evidenced with some reflection however actions agreed are not SMART.
- Supervision Agreements to be up to date.
- Some unannounced visits out of timescale.
- Children's bedrooms are not always seen by the fostering social worker during home visits.
- Training needs to be developed for both fostering and Childrens social workers to understand the SGO process and initial conversations to support foster carers decision making.

Areas for improvement and what we can learn from this both individually and organisationally:

- Refresher protocol training for some FSWs to ensure that they save documents in the correct area – auditors had to plough through case notes and documents to find some information that should have been in a specific area on protocol.
- FSW to be aware of the expectations for unannounced visits and unsuccessful unannounced visits to be logged so that a clear record is kept.

- Expectation for all Reg 24 placements to have an unannounced visit during the initial 16 week temp approval.
- Supervision Agreements to be completed and signed every time there is a change of FSW.
- Training records to be kept up to date.
- Delegated Authority and Unannounced Visit forms to be inbuilt into protocol via forms to help with monitoring.
- Supervision records to be shared with carers and a signed copy uploaded to protocol to evidence they have seen it.
- Management direction to increase when foster carers do not engage in training/supervision sessions.
- Signed copies of documents to be uploaded to Protocol.
- Case Summaries to be kept up to date and relevant.
- Organisationally staff need to ensure core documents are signed by carers.
- Some FSW's would benefit from attending the supervision workshop to ensure effective support and challenge is evident in supervisions.

Foster Carers views of the fostering service

How well do you feel you are supported by your Fostering Social Worker?

"Exceptionally supported by our fostering social worker - 120%, it's got to be more than 100% because she is amazing."

"The support we receive is exceptional, FSW and SW are both really good and helpful – they are kind, considerate and she can go to them about anything."

"Brilliant. 5 stars. She's lovely and really helpful."

"Amazing, he is amazing and is everything you need in a social worker, supportive, emotive and informative. Wears his heart on his sleeve."

"Communication with the fostering team has improved greatly - honest lines of communication with foster carers, much better than when we first started."

"Really good, we were struggling with our foster child and at one point, LW called us every day to offer support and advice and J would call regularly."

"Great, had the same FSW since the start. Keeps in contact via phone, emails, regular home visits. Answers questions and finds the information we need. Nice. No complaints."

"I feel that we have made the right choice by coming over to Telford from an independent fostering agency – we are really happy with Telford Fostering Team."

How would you describe communication with the fostering service?

"We have not experienced any issues getting in contact with our fostering social worker or the child's social worker; they are both very approachable and supportive."

"Communication with the Fostering Team is excellent, there is always someone to speak to, no issues. If we call the team and there is no one available to speak at that time, then someone always returns the call when they are free."

"All the managers in the Fostering Team are very approachable and take on board what foster carers say and act upon those things - things are much better now than when she first started."

"Really good, always able to get hold of people if needed."

Positive feedback received for the Fostering Team:

"A couldn't praise J enough for her ongoing support, regular visits, and giving them a clear understanding of the process and what is expected of them ready for panel. A said that herself and D are very grateful for all her support, advice, and guidance."

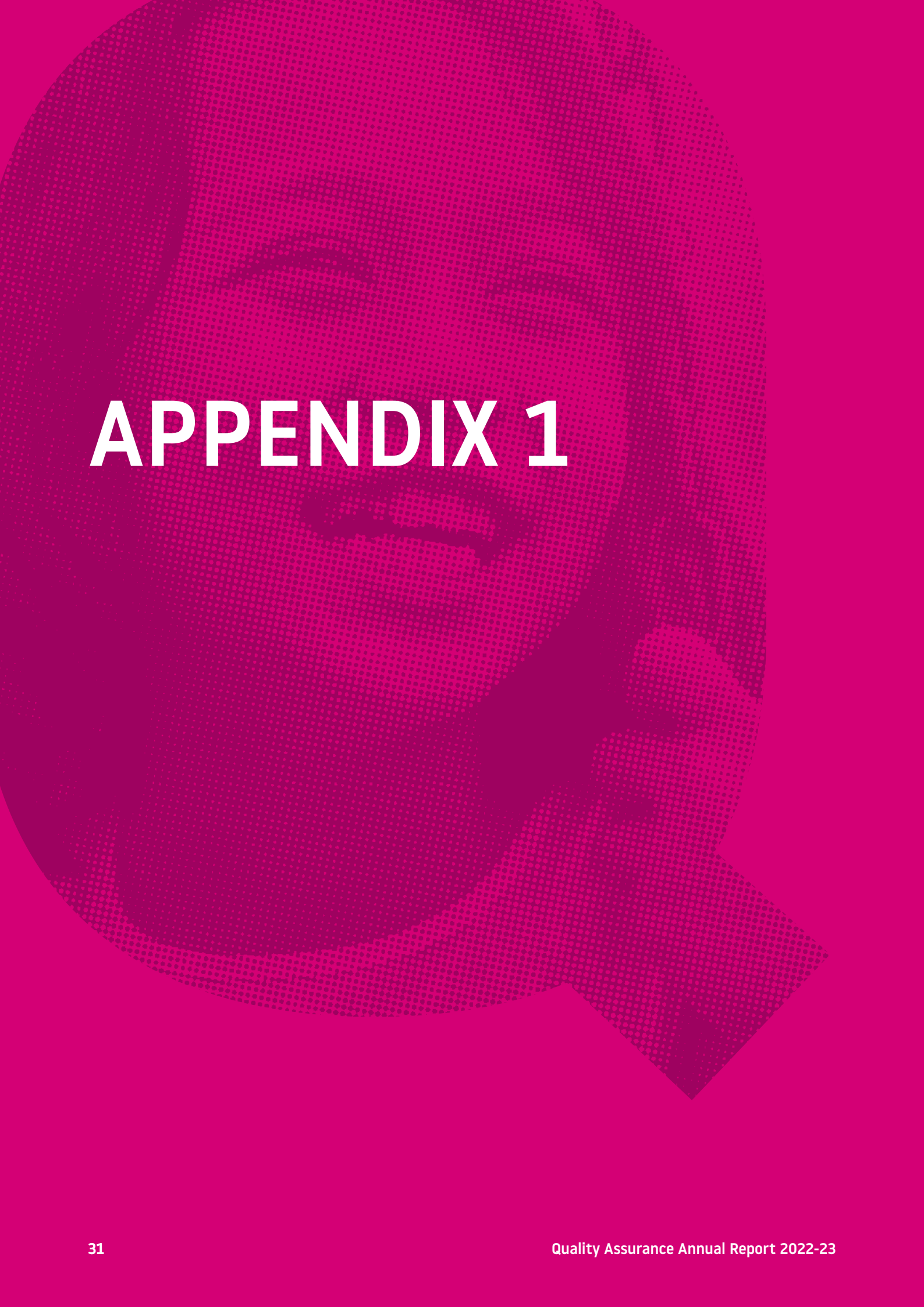
"We would also like to pass on our thanks to L for all she has done to help us. She really has gone above and beyond to support us and ensure C is supported in the best way. We are very grateful, and we just wanted you to know how much we appreciate all she has done for us."

"TC is, and always has been, amazing. Nothing is too much trouble, and she is always so helpful. There is never any pressure to take a placement – she also ensures that our payments are correct and on time."

"TC is great. She is always quick to answer emails or phone calls. She will also come back to me as soon as she can with updates about respite etc."

4.0 Our Plans for 2023-2024

- To continue to review audit tools to ensure that they are fit for purpose.
- To embed moderation by service delivery managers for audits undertaken from within their own services.
- To refresh the Quality Assurance Framework, with a focus on recent development such as the Language Guide.
- To further develop the Family Safeguarding Quality Assurance Framework.
- To continue to promote "closing the loop" to ensure that learning from quality assurance is used in a meaningful way.
- To develop improved strategies in responding to learning from complaint themes.
- To involve a wider staffing group in audit activity e.g., SSWs.
- To continue the close working relationship with the PSW to provide fit for purpose support, resources and training for staff across all services.



APPENDIX 1

APPENDIX 1

Deskside discussion with practitioner

Manager holding the discussion
JP, Service Development

Practitioner
B Step up Student about to qualify and passionate about working in Telford & Wrekin

Date of discussion
17.01.22

B shared some casework she is doing with a mother who had a baby removed at birth but following proceedings and interventions is having the opportunity to be reunified with her child. **B is co-working** and was introduced to support mother during the time of transition. B was able to speak about the case and **her pride and pleasure in the successful reunification casework was evident**. B was able to explain mother's feelings about a new practitioner but also the methods of work used to reassure and respect mother while being clear about the purpose of work and the importance of outcomes for the baby. Evidence shared of casework, recording which was written to the baby directly and also to mother – **excellent examples** of child and parent focused case recording. **Safety planning, SW consultancy and management oversight evident.**

Describe any recent pieces of work with a family are you most proud of?
B described the work above and was clear about the support offered by the social worker and the TM. B was clearly (and rightly) proud of this work.
B was able to find all the documents I asked to see – including supervision

This casework could be offered as an example of writing to the mother and the child. The Family Safeguarding workbook is being used and we discussed some confusion and recording on protocol then also in the workbook, but B clarified this is now sorted out and she records in the workbook which pulls forward into protocol.
B is really passionate about this piece of work and also feeling that her past experience has been acknowledged and respected.

What direct work with a child has gone particularly well?
B spoke about direct work with two sisters L and A. B was able to show me the originals of the work and show how she had used the printed tools to have a getting to know you session with the girls – pointing out their responses which evidenced that she had their involvement in the work. The work had been challenging as their mother had told the children not to talk to her in case she took them away. B was able to work through this honestly with the children explaining her role and understanding that the children were unsure as another sibling has a CP plan and a SW rather than a student. B also spoke with Mother and was able to work through her feelings respectfully but clearly. The direct work evidence was great but not yet uploaded to the case records – see challenges.

I was really impressed with the planning and management of this work which was both respectful of Mother's fears but also able to challenge as necessary to achieve a relationship with the children and assure them of her role.

What about any challenges you have experienced recently?
As B is a Step-up student, she is not provided with an access code to use the scanner and upload her own work. B has passed the work to BSO to scan and place on the records for her but was able to share the originals with me.

This is something that could be reviewed.

B had no other examples of challenges – yes there are plenty for her and in the teams but there is always support and guidance on hand. The managers are available and cover for each other and the SDM also walks the floor and has discussions with people. The service is warm and welcoming "you are never alone; this is a safe space with plenty of guidance and support".

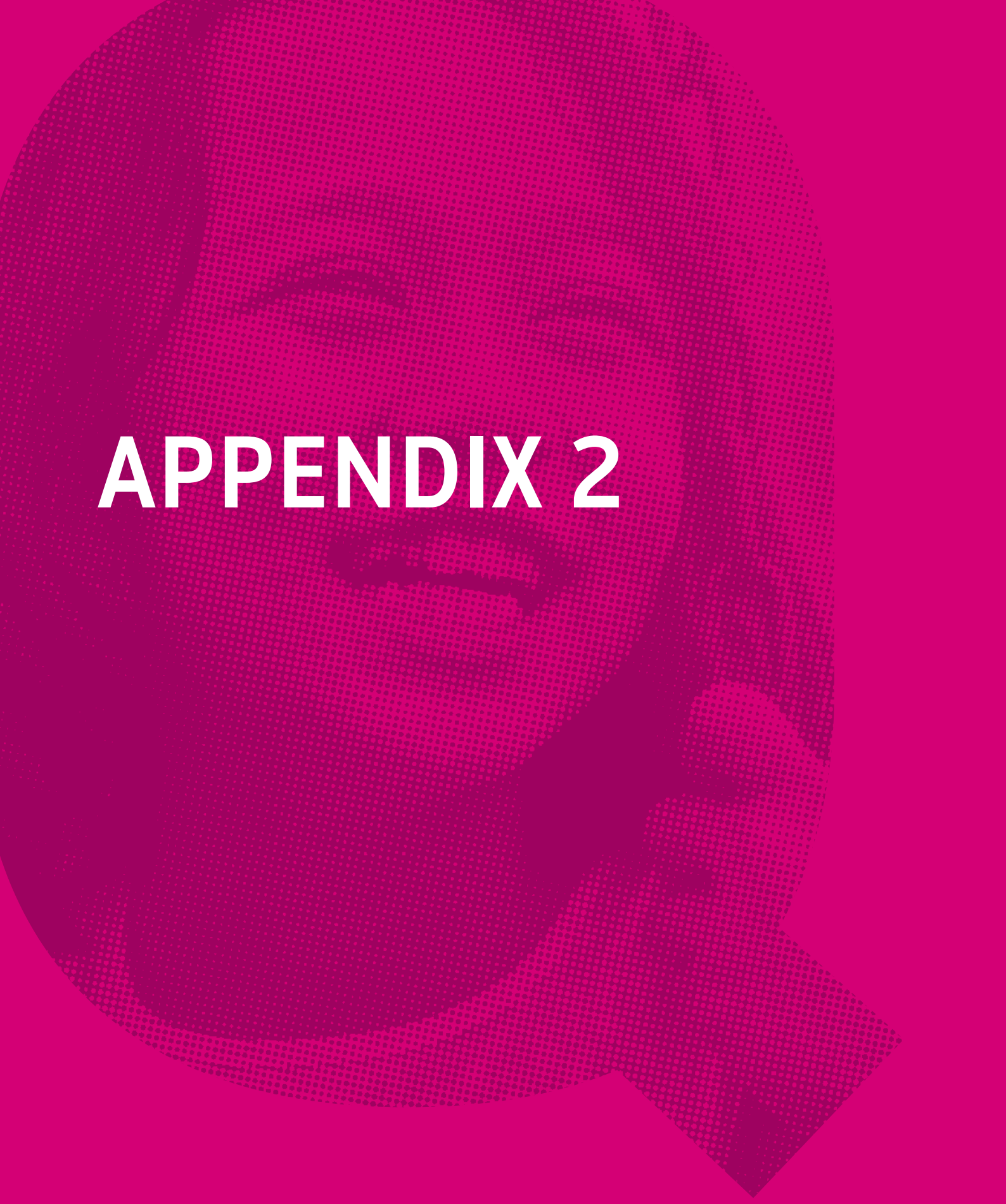
Is there any other feedback that you would like to give about your work?

B reflected on the development of the FS model and spoke positively about the advantages to families of the adult workers being in the teams – great for families and the service that they don't have to wait months for a community-based referral but have that support when it is needed.

B was a FSW in Telford and Wrekin for many years but wanted to further her career. She left and went to another LA to have the chance to advance via the Step-Up programme. In this placement B is well supported and in the case example spoke about the role and support offered by the SW which is reflected well in B's understanding and delivery of the allocated work with the family.

Now on placement here B is 100% committed to getting a job as a SW in Telford and Wrekin which has always been her ambition. This is a really great place to work – for the support you get as a professional and because in T&W they genuinely care about children.

I really enjoyed this deskside discussion with B, her respect, care and passion for working.



APPENDIX 2

APPENDIX 2

Example of a letter to the child

Hello XXXX and XXXX

I met with you both after school today, XXXX you were asking me lots of very interesting questions about what I did when I was little, where I went to school and what I liked to do, I told you I liked to help my daddy in the garden as he grew fruit and veg, you told me "That's short for vegetables" I also told you I went to school near my house and that I liked to play at the local playground, and that I had cut my knees on the slide, You made an "Ouch" noise and look a bit concerned, I told you I had plasters on my knees and that I was ok.

I asked you and XXXX if you'd learnt anything fun at school, M, you told me more about the Egyptians and that they lived in BC, you remembered the B was for before, which I think is so clever.

XXXX, you were more interested in what we were going to do and what was in my bag, you had noticed a small white bag in my big bag and asked, "What's in the white bag?" I told you "When we have done some work, I will show you!"

Both you and XXXX worked so hard today doing five worksheets each all about your family, XXXX you did really good writing and you both drew lovely pictures of you mum, dad, brother and sister. XXXX, you asked me to write your words down, I think you were a bit tired today as you had a lie down at one point, that was fine, I know how good you are at school and how hard you work, you too XXXX, you both love to learn.

It was soon time to tidy away, which you both did without me having to really ask, then I got the white bag out, I explained that sometimes when children have worked extra hard I took out a reward bag and that's what the white bag was, I invited you both to pick a reward, XXXX you kindly let XXXX go first, then you had your turn, I had also taken out some stickers and gave you both a "good work" sticker from me as I was really proud of you, I let you pick a sticker each too.

I took you out to meet Mum and X and thanked you both again for your hard work. I told them how well you had worked and that I had let you pick a reward, which you proudly showed off to mum and X. I really hope you felt proud of the great work you had done today.

See you soon

Quality Assurance Report provided by Helen Smith, Quality Assurance Lead – May 2023