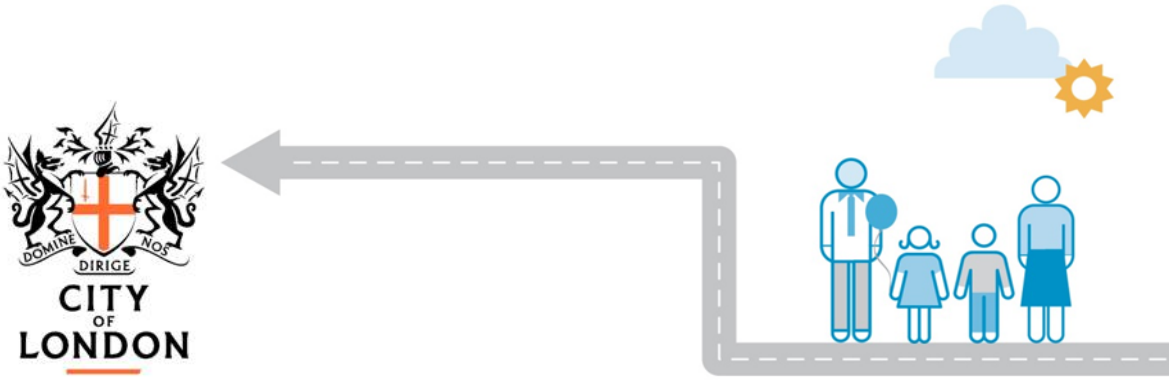


# Annual Quality Assurance Report 2018 to 2019

## Introduction

This quality assurance annual report will be focusing on the outcomes of audits and reviews that have been completed on cases open to the Children's Social Care and Early Help Service from May 2018 to June 2019. The report will identify the purpose of the audit or review and the key findings, with a focus on the outcomes that have been achieved. The City of London commissions an independent service to review and audit case's open to the Children's Social Care and Early Help Service. This independent service is a not for profit organisation made up of senior managers who have significant experience in frontline children's services. They also carry out quality assurance activity across many other London boroughs and are able to bench mark the City's progress against these boroughs.

Currently the City of London has the independent auditors in twice a year, with half the cases being audited in October /November and the second half in April/May of the following year. Recommendations from these audits are reviewed in a meeting chaired by the Assistant Director of People, called 'getting from "good" to "outstanding"'. This ensures that recommendation from audits are responded to in a timely way. Thematic issues identified in the audits are addressed through the Service Improvement Plan, which is updated on a regular basis by the Children's Social Care and Early Help Service Manager.

This year there has also been a review of the Quality Assurance Framework, which has taken an approach of aligning with the journey of children and families through the services they receive. Supporting staff in delivering outstanding services through a robust learning and development programmes that supports their skills and confidence as practitioners.

There is also a survey carried out by "Action for Children" on all the children and families open to Children's Social Care and Early Help Service, this survey is undertaken on an annual basis. The outcome of this survey has been included within this annual report and corresponds with the independent auditing completed in May/June 2019.

City and Hackney Children Safeguarding Partnership carry out multi-agency audits twice a year, the theme of these audits is decided by the partnership and is an opportunity for learning with partner agencies. In 2018 to 2019 the focus of the multi-agency audits was on Early Help and Adolescent Mental Health, the attention on adolescent mental health followed two suicides that occurred in Hackney, where they were subject to a Serious Case Review.

Thematic reports can also take place during the year, as and when required, in 2018 a thematic audit was completed on contacts and referrals over a three-month period. This audit was to establish the baseline on the application of threshold, as the Team Manager's post was going to change to be a job share, whereby two managers would be sharing the role, with one manager doing the beginning of the week and the other doing the latter part of the week, with a crossover midweek.

The Children's Social Care and Early Help Service has gone through a period of considerable change this year in relation to the Team Manager role and social work team. It is a generic children's team that covers adoption through to leaving and aftercare services, the highest

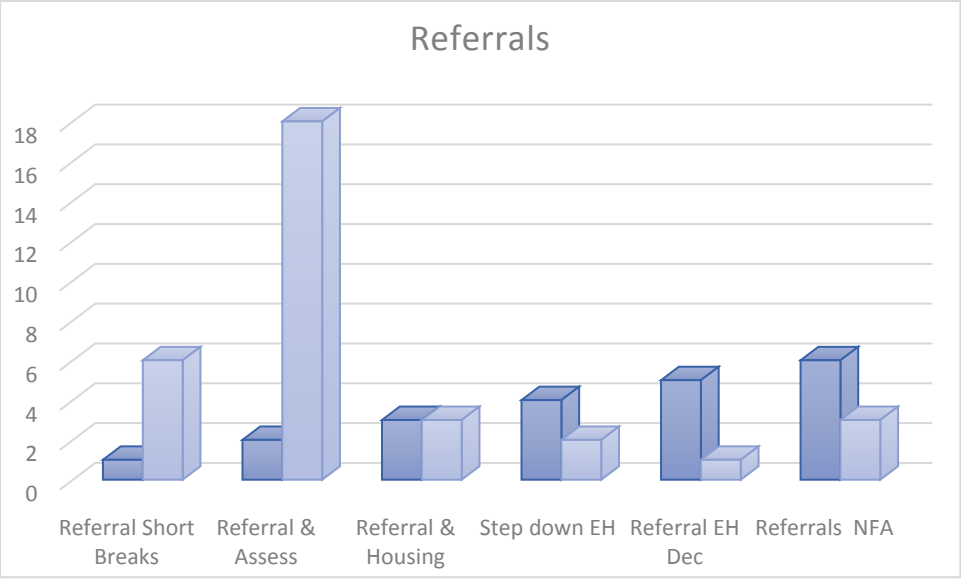
proportion of young people open to the team are unaccompanied asylum-seeking children (UASC). There has been a significant increase in the number of UASC being cared for by the City of London, which has had a direct correlation with the National Transfer Scheme. The majority of social workers when they first start at the City have limited experience with UASC, so often there can be a skills gap in this area for new staff. The City does provide shadowing opportunities and training; however, it is recognised this can lead to a drop-in standard in relation to care leavers initially. To support this potential area of risk in relation to standards a Pathway Plan Review was completed by the Quality Assurance Service in June 2019.

Currently the Children's Social Care Service are changing to a systemic practice model, which is being supported through training for staff and support from experienced systemic practitioners.

## Audits on Contact and Referrals between May and July 2018

Thematic audits were completed on all contacts and referrals over a three-month period between May and July 2018, this was to establish a base line on the application of thresholds in the Children's Social Care and Early Help Service. In regard to the referrals the decision making presented as being clear with the appropriate application of thresholds. The three referrals where there was no further action related to two families in total and there was no evidence to suggest that these needed to be progressed as there was no remit for the Children's Social Care and Early Help Service. Fig 1 shows the distribution of referrals in relation to the presenting issues.

**Fig 1 Referrals received between May to July 2018 and decision**




In relation to contacts there were 46 contacts in total between May and July 2018, 12 of those contacts were maternity alerts, and were for information only. There were 28 contacts in relation to children who are known to social care who had gone missing from the

London area and across the country. Six children linked to other reason's; one contact related to a CafCass enquiry, ascertaining whether a child was known to the City of London children's team. Another contact was in relation to three children on a child protection plan who were staying temporarily in the City of London, one was in relation to a child being referred to the vulnerable adolescent's group. The last contact was in relation to a domestic abuse incident, the child was already known to the Children's Social Care and Early Help Service. Overall there were no concerns identified in relation to the application of thresholds in respect of contacts.

## Independent Auditing Completed October/November 2018

As previously mentioned, the City of London commission's an independent provider to complete audits on all the open cases in the Children's Social Care and Early Help Service. Half of the cases are audited in October/November and the other half in April/May of the following year, this forms the auditing cycle for the City of London.

In October/ November of 2018 a team of three auditors, audited the records of 17 care leavers from a list of open children's cases, the cases were audited between 10/10/2018 and 14/11/2018. The audit tool used by the auditors was designed to measure impact and outcomes for young people, as well as the procedures used within the Children's Social Care Service, information was obtained from Mosaic, the electronic recording system for children's records and from social workers. The information obtained is appropriately triangulated and quality assured, then shared with the social workers and their line manager.

**Key Findings**

**Strengths**

**Assessment**

- Assessments are usually contained within Pathways Plans and Risk assessment documents and are based on meaningful, purposeful and child focused visits with good use of observation and appropriate tools in direct work in most cases.
- There is strong evidence of commitment to good social work practice based on developing positive and meaningful relationships with young people/parents and carers, with a sensitive approach to difficult and sometimes challenging discussions across all case types. Practitioners clearly work hard to engage children and their families and show a determination to 'stick with it' especially around challenging behaviours.
- Chronologies and case summaries were found on almost all case files and these were helpful in providing clarity about the history and direction of the case. This is a clear benefit of the Corporation's investment in Mosaic as a children's database.
- There is also evidence of the use of risk assessment templates.

**Implementation and intervention**

- Our findings this year are similar to those from last year's audit programme. Social workers, the Independent Reviewing Officer (IRO), first line and senior managers demonstrate an impressive breadth of knowledge and expertise in supporting asylum seeking young people.
- Care Leavers are really well supported and broadly speaking are well prepared for independence. They are supported well by the team around them including the Virtual Head and there is good evidence of the use of mentoring, via Mylife.
- There are good examples of visit recordings that evidence meaningful engagement with young people and their families/carers. However, these are sometimes delayed in being written up and uploaded onto Mosaic.
- There is little reference or evidence that practitioners use a specific practice model. There is reference to "systemic" approaches and "Think Family" and some supervision sessions follow a sign of safety or strengths-based approach, this is not consistently applied.

**Planning and Review**

- There is some evidence of SMART planning, although outcomes in some plans tend to be in the form of a set of objectives. This makes it difficult at times to measure progress and impact.
- Written plans tend to lack contingency plans or exit strategies. Whilst it is admirable that the City of London's approach is to provide support routinely for all care leavers until they reach the age of 25 (which has been policy for a number of years and in line with more recent statutory guidance) or unless they request that it is withdrawn, it may also increase dependency upon services, rather than support autonomy and independence.
- There is evidence of good, meaningful Personal Education Plans and robust support from the Virtual Head.

**Areas for Development**

**Supervision and Management oversight**

- Evidence of management oversight seemed less evident than in previous audit programmes. There were limited records of management oversight recorded on file.
- Auditors found no evidence on case files that managers observe practice. Recommendation: to improve management oversight and provide confidence in practice, Team Managers should undertake joint visit and direct observations of practice.
- Some supervision seemed loosely based on a Signs of Safety template, including the voice of the child and updates on actions from previous supervision. However, much supervision was often bland, lacking reflection and not driven by outcomes. Actions tend to appear as list of tasks with few timescales set and very often, actions would be repeated (in some cases noted 3 times) without follow up. Recommendation:

ensure supervision policy is fit for purpose and ensure supervision is reflective, outcomes focussed and is driving care planning for children and young people.

- Supervision notes are not always uploaded promptly.
- Delays in the completion of pathway plans have been identified for one specific social worker in the past 3 audit programmes and improvements have not been observed during this programme of audit. Management accountability and expectations are not always clearly outlined with actions taken to address poor performance and we would recommend that management expectations, roles, responsibilities, delegation need to be reviewed by the Corporation. Recommendation: With support from HR, ensure team managers and service managers have a clear understanding of policy and procedure in relation to managing poor staff performance.

Overall auditors considered that Social workers in the City of London knew their young people and were working hard with them to have sensitive, challenging discussions which were in their best interest.

**Recommendations**

1. Introduce case-mapping in group supervision sessions to focus on complex case work to foster effective shared understanding of risks and needs.
2. To improve management oversight and provide confidence in practice, Team Managers should undertake joint visit and direct observations of practice
3. Ensure supervision policy is fit for purpose and ensure supervision is reflective, outcomes focussed and is driving care planning for children and young people.
4. With support from HR, ensure team managers and service managers have a clear understanding of policy and procedure in relation to managing poor staff performance.

**Outcome**

1. The Children's Social Care and Early Help Service has introduced group supervision, this is taking place across the various teams in the people directorate.
2. The City of London has a new supervision policy and template for supervision which supports reflective, outcome focused care planning for children and young people.
3. Any case specific recommendations have been progressed through the getting from "good to Outstanding Meeting" which is chaired by the AD People, only when evidence or commentary has been given as to why it in not required will the recommendation be signed off as completed.

## Multi Agency Audits January 2019

Multi agency audits on three Early Help cases were organised through the City and Hackney Safeguarding Children Partnership, the scope of these audits was to identify the key strengths and areas of development in relation to multi-agency working with children and families in the City of London. A meeting for agency leads and front-line professionals was held on 9th January 2019, three cases were selected from the City of London's Early Help service, to ensure proportionality, the audit focused on agency involvement/intervention from agencies in the last 12 months. This meeting was well attended by all agencies involved with the children and families, and generated discussion and challenge.

Case 1 – Child & Adolescent Mental Health Services (CAMHS) referred a young person as his mother was having difficulty in managing the young person's behaviour, the case had been stepped up into statutory services due to domestic abuse.

Case 2- Referred by Housing as family were at risk of eviction, case was stepped up to statutory services following an accidental overdose by the child's mother.

Case 3 – Mother and child supported by Early Help as both subject to health and learning diagnosis, family were stepped up to statutory services following the birth of a new sibling for a child and family assessment, then stepped down to Early Help when completed, whereby mother of the children withdrew consent to engage.

**Key Findings**

**Strengths**

- The was evidence of supervision and management oversight by the Children's Social Care and Early Help Service.
- Evidence that thresholds had been applied appropriately, which evidenced an improvement from audits completed in 2015/2016.
- In case 1, school relayed their experience of Early Help has been their "best ever "including working with other boroughs.
- In case 1 the Health Visitor is aware of older children's needs and parental mental health.
- Case 1 Evidence of the young person engaging with the Team Around the Child (TAC) meetings.
- In case 2 the was evidence of professional curiosity where there was evidence of financial abuse.
  Case 2 – evidence of Victim Support co working with the social work team.
- Case 2 – Evidence of practical support for mother through support of financial advisor.
- In case 3 the Early Help offered presented as being strong and despite mother's difficulties, the children were held in mind. Professional were also described as being tenacious in ensuring good outcomes.
- In case 3 although the mother had disengaged, but evidence that other professionals involved with the family are able to alert other agencies if concerns increase.

- Case 3- GP recognising the impact of mother's learning difficulties following a series of unattended appointments for the child.

**Areas for Development**

**Engagement and inclusion of Fathers**

- Case 1 – the multi-agency audits identified concerns around the engagement of fathers, and how absent fathers are still important as they are part of the child's identity in relation to diversity and heritage.
- Case 2 – the engagement of father ceased when he was found to be a perpetrator of domestic abuse. It was highlighted that this was an issue in the 2015 to 2016 audit findings, it was identified that;

  *"Father was seen as a perpetrator of domestic violence although assessments and plans could have reflected his specific health needs and then the impact this had on the family. There was also a lack of understanding around beliefs/culture, faith and gender roles. Having a greater understanding of a family, their needs and current circumstances will help support future plans"*

**Safeguarding First**

- The audit findings identified the importance of determining the reason why a child did not attend an appointment, i.e. Did not attend vs Was not brought, this was identified as an issue in the 2015 to 2016 audits.

**Recording Information**

- In case 2 it was identified that some agencies were not recording the information, a recommendation from the multi-agency audit is that all agencies need to keep records up to date.

**Information Sharing**

- It was identified in case 2 that the GP had not been advised of the families change of address, the Health Visitor had been aware, but this had not been conveyed to the GP.
- In case 3 it was highlighted that as Early Help is a consent-based service, if parents do not engage, professional should be looking for evidence of potential risk before closing the case.

**Outcome**

The areas for development are included in the City of London's action plan and agencies are held to account in progressing the actions from the multi-agency audits, this plan is

reviewed within the Quality Assurance Subgroup of the City and Hackney Safeguarding Children Partnership (CHSCP).

## Multi-Agency Audits June 2019

Following two serious case reviews on two adolescent suicides in Hackney the CHSCP decided to review case where there were adolescent mental issues for the multi-agency audits in June 2019. The City of London had one case being put forward for the multi-agency audits and again, to ensure proportionality the audit was focused on agency involvement/intervention in the last 12 months.

The City of London's case involved a young person admitted to an adolescent mental health unit, an assessment had been completed by the Children's Social Care Service and closed. The young person had a recent diagnosis of Autistic Spectrum Disorder. The professional network was co-ordinated by CAMHS Care Co-Ordinator. There has been a disclosure of historical abuse made by the young person.

**Key Findings**

**Strengths**

- Education services have and are involved with this young person even though there is no statutory requirement, i.e. Young person missing in education.
- There was a good level of professional attendance at the Child in Need (CIN) and Care Programme Approach (CPA) meetings.
- There was reflection on social media usage re suicide contagion and learning from serious case reviews to assess level of risk, case was also reviewed in the City of London's "Top 3" meeting due to the risks.
- The voice of the young person was confidently relayed by the CAMHS Care Co-Ordinator, which helped assess risk and safety planning with young person.
- Timeliness of interventions such as strategy discussions with key partners was good.
- Sensitivity shown to young person by the social worker when he was critically unwell.

**Areas for Development**

**Information Sharing**

- Education Service to improve links with Academies to enable information sharing around vulnerable children, i.e. low attendance (<90%)
- CAMHS to ensure key agencies are aware of changes in safety plans, invited to CPA meetings and for in-patient/discharge meetings.
- Better partnership understanding of the School Nursing Teams to ensure the right professionals are informed of CIN meetings/ relevant correspondence/ discharge planning.

- Clarification for the Children's Social Care Service re seeking consent from parents.
- Caution around hypotheses in relation to behaviours being medicalised.
- Continued professional curiosity around absent fathers/ paternal extended families can help identify the wider support network.

**Outcome**

The areas for development will be included in the City of London's action plan, all agencies are held to account in progressing the actions from the multi-agency audits, this plan is reviewed within the Quality Assurance Subgroup of the City and Hackney Safeguarding Children Partnership.

## Review of Pathway Plans and Supervision 21st June 2019

As part of the City of London's journey towards providing outstanding services a review in relation to quality and compliance was completed on Pathway Plan's and Supervision. This was completed on Looked After Children and Care Leaver cases, the Assistant Director of People, Children's Social Care and Early Help Service Manager and the Safeguarding and Quality Service Manager were involved in the reviews. All the cases were checked on Mosaic, overall the Pathway Plans were within timescales and supervision was present in the majority of cases. Where action was required this was recorded as being outstanding, with clear timely recommendations on what need to be done, which would be picked up with the Team Manager by the Social Care and Early Help Service Manager.

## Independent Auditing Completed April/May/June 2019

Between May and June 2019 independent auditors audited 58 cases out of a potential 83 cases, they excluded cases that had been audited in October/November 2018. The auditors noted a significant increase in cases from 66 in October 2018 to 83 in April 2019, which represents a 28% increase in 6 months between October 2018 and April 2019. Key areas of development were in relation to contextual issues and the inclusion of wider family, strengths were identified as being the relationships between the young people and their social workers.

**Key Findings**

**Strengths**

**Referral and Response**

- The Quality of referral and contact forms continues generally to be good, although multi-agency referral forms from the single City of London school do lack detail.

**Assessments**

- There was very strong evidence that the impact of diversity on looked after children and young people is considered and that when foster placements are not a strong cultural match other resources will be brought in to support the placement.

**Implementation & Intervention**

- Social workers, Independent Reviewing Officer (IRO), first line and senior managers demonstrate an impressive breadth of knowledge and expertise, particularly in supporting asylum seeking young people.
- Care Leavers are really well supported and broadly speaking are well prepared for independence. They are supported by the team around them including the Virtual Head and there is good evidence of the use of mentoring, Mylife.
- The Early Help practice audited was purposeful and well-focused on specific outcomes for children. All of the cases that were audited were graded as "good". The quality of intervention is very good, and supervision of these cases is much more reflective and thoughtful.
- Responses to new referrals of UASC that are assigned to City of London are timely and appropriate. Practitioners and managers know exactly what to do and action checklists are uploaded as management notes to ensure that nothing is missed. This means that Personal Education Plans (PEPs), Looked After Children (LAC) Reviews and Initial Health Assessments are booked quickly and efficiently.
- There are good examples of visit recordings that evidence meaningful engagement with children/young people and their families/carers.
- Social workers continue to go "above and beyond" for some young people they work with. Auditors found evidence of good professional communication and working together as well as excellent support of a young person through several appeals processes, and a commitment to attend court from one worker who had already left the services of City of London.
- Auditors also found excellent outcomes for a sibling group of two, who have been adopted together, therefore maintaining the sibling relationship. There was also evidence of a high-quality support being offered to the birth parent during this difficult period.

**Planning and Review**

- In the sample of 16 LAC cases that were audited, there is evidence of good quality LAC reviews. LAC Reviews are recorded as a letter written to young people.
- The IRO "footprint" is apparent on most files with evidence of timely midpoint reviews and ongoing scrutiny and oversight by the IRO in specific case notes. This helps keep cases on track and avoids drift. There is also clear evidence where the dispute resolution procedure has been activated and escalation is carefully recorded, with the rationale for decisions being explicitly recorded.
- There is evidence of good, meaningful Personal Education Plans and robust support from the Virtual Head to ensure that young people are in education, employment or training. Tuition is provided to support UASC who are on the National Transfer Scheme (NTS) and unable to access formal education. There is clear evidence of supportive, child focused practice in this area.

**Supervision and Management**

- The audits identified that the records of supervision in Early Help demonstrated regular monthly meetings, good reflection and more curiosity regarding underlying issues.

**Areas for Development**

**Referral and Response**

- Responses to referrals are always timely but were not always deemed to be proportionate and did not generally refer to the City of London Thresholds of Need.
- Auditors found that in some cases there needed to be more rigour at the point of referral in gathering further information from referrers.
- Whilst practice at the referral stage is prompt, at times it is over-reactive rather than considered, leading to intervention that is sometimes not well-planned or proportionate.

**Assessment**

- many assessments lack depth and analysis. They are not always comprehensive and informed by all information available from members of the wider family (non-resident fathers in particular) and other professionals.
- There is little evidence of the use of contextual safeguarding or the understanding/exploration of risk outside of the family unit/placement. There is a lack of evidence to suggest that ecomaps were used consistently to map social relationships, in understanding where risk and safety lie particularly for children who were looked after.
- In some Child in Need cases, the child's voice was not as clearly evident as the parents' or given due weight. The high needs of parents at times took the focus away from assessing parenting capacity and risks to children.
- Whilst chronologies were found on almost all cases, these tended to describe children's services process events e.g. visits made, meetings held, case transfers, assessments completed rather than providing information on the child or any concerns at that time and the outcome for the child.

**Implementation and Intervention**

- Often, social workers "refer out" to other agencies and professionals, rather than undertake direct, relationship focussed work with young people.
- There is a lack of recognition of the skills of the case holding social worker and the potential positive impact of their direct work with children, parents and families.
- There are a very low number of young people who are missing from care or whose whereabouts are not known in the City of London, however in cases where children being missing was a feature, there was limited planning, curiosity and coordination of information to obtain a clearer picture of where the child goes when not in placement.

**Planning and Reviews**

**1.** Plans do not consistently reflect what needs to change for each child/young person and how progress will be evidenced and measured. There is some evidence of SMART planning, although in most cases, outcomes still tend to be in the form of a set of non-specific objectives, making it difficult to measure progress and impact.

**Supervision and Management**

**2.** Supervision records need to evidence greater challenge of practice; some cases have repeated actions running from one month to the next, with not much evidence that the actions have been undertaken by the worker.

**Recommendations**

1. Recommendation: that the City of London consider arranging training and development opportunities regarding Contextual Safeguarding to inform staff

2. City of London managers to highlight with Sir John Cass School expectations regarding the quality of referrals

3. City of London management team to review the process for triaging referrals and applying thresholds with reference to referrals that did or did not reach the threshold for Tier 3/4 intervention.

4. Referral and contact forms would benefit from more narrative from management to evidence reason for decision.

5. Senior management to review the practice of, and guidance for, assessment planning and oversight (including the planning of s47 enquiries).

6. Develop a LAC pack for unaccompanied asylum seeking children, explaining the purpose of different meetings and the roles of different professionals, in the child's own language, to help reduce anxiety and simplify the processes

7. Induction and subsequent training to focus on direct work, use of direct work tools, how to respond to unmet emotional needs that do not meet the remit for CAHMS intervention, how to improve child focused planning and settling in of UASC children, improving understanding of the child's world outside of placement.

8. Include Guidance for Missing Children and return Home interviews in City of London Practice Standards and embed this through training and development on return home interviews, how to gather information and understanding the missing/Away from placement without authorisation episodes to help understand missing episodes and how this will form part of risk assessments and assessments of need/Pathway planning.

9. Develop a missing grab pack to provide to foster carers at the point of placement and for the IRO to check the pack is ready as part of the Independent LAC Review process.

10. To include a checklist for managers to facilitate the monitoring of the completion and quality of key tasks and documents.

11. To improve management oversight and provide confidence in practice, Team Managers should undertake joint visits and direct observations of practice.

12. Amend supervision policy to require managers to observe practice and to require managers to demonstrate on the supervision record that they have checked actions from previous supervision have been carried through.

**Outcome**

At the time of writing this report the recommendation are in the process of being progressed, the following work has already been started;

1. The Children's Social Care and Early Help Service, Safeguarding and Quality Assurance Service and the AD People are currently being trained in systemic practice.
2. The City of London has commissioned a training and development for the Children's Social Care and Early Help Service with LB Hackney, staff can access this training via the Social Care Learning Programme.
3. Practice Observations have commenced, staff across all levels from the DCCS through to frontline social workers are included.
4. The current guidance on Children Missing from Home and Education is being updated.

## Action for Children, Annual Survey - Views of Children and Families

During April to July 2019 Action for Children carried out the Annual Service User Survey on children and families open to Children's Social Care and Early Help Service. This included Early Help, Children in Need, Children Looked After, Child Protection and Care Leavers. Overall this survey was positive regarding the intervention they received from the Children's Social Care and Early Help Service.

The total number of children and young people eligible for the survey was 62. The total number of responses received was 39, making for a 61.2 % response rate (Compared with a 58.7% in 2018) Children young people and families where contacted by postal questionnaires or via telephone interviews.

Below are some of the comments that came from children and families in relation to their social worker;

"She's new but she's good…always there."

"She's friendly. Before I had J. She was brilliant."

"She understands me. She's the same age as my big sister."

"She's a nice lady, always answers the phone or messages me. All my social workers have been very good."

"She replies quickly, and we meet every 6 weeks. I'm happy with that."

"I trust her."

"Everything I like, she says 'ok, we'll do that.'"

"I know him long time. Always listen to me."

"They are so friendly, so helpful."

"She's kind. But she's leaving in July."

"Any problem I have, I ask for help. The keyworker sorts it out, mostly, not my social worker."

"They care about my life and what I do."

"Any problem, they help…the keyworker too."

"I can ask my social worker and keyworker anything. We know each other well. Once I have a job we'll have less contact."

"He always allows me to give my opinion."

## Summary and Quality Assurance Analysis

This report has reviewed the quality assurance activity that has taken place over the past year. Individual case improvements have been addressed expediently through the getting from "good to outstanding" meetings which take place approximately 1-2 months after the independent audits. These meetings record what actions have been taken and only when evidence is available will the recommendation be signed off. Thematic, procedural and policy issues will be included into the Service Improvement Plan and Practice Standards, were there will be timely plans in place to progress recommendations.

As identified in the introduction of this report there have been significant changes in the Children's Social Care and Early Help Service, there have been three managers and three social workers who have left over the past year. This has been due to natural career progression for some members of staff and the recruitment of permanent staff in posts where there had been agency staff covering or filling temporary posts which have now become permanent. In a small team this has been a significant change, many cases have only recently been allocated to staff and some of the practice issues do not relate to current staff.

Independent auditing will take place in October/November 2019, this round of audits is more likely to give a more accurate picture of the current practice within the Children and Families as staff who were new in April. In October/November 2019 staff will have had an

opportunity to settle into their role and get to know the children and young people they are working with.

As previously mentioned, staff are being trained in systemic practice and this is taking place currently. Support in embedding systemic practice is being achieved through the commissioning of experienced systemic therapists to help embed the practice in the City. This was identified as being key through the PSW network in ensuring that practitioners felt confident in using this model

There are thematic issues that have been identified in relation to contextual safeguarding and the inclusion of fathers as part of the assessment process. It is envisaged that the learning in regard to systemic practice will assist in supporting development in this area. The City of London has also been involved with the current research around affluence and neglect, further research in this area is currently taking place and this will support future learning and development for staff.

Pat Dixon

Safeguarding and Quality Assurance Service Manager

August 2019