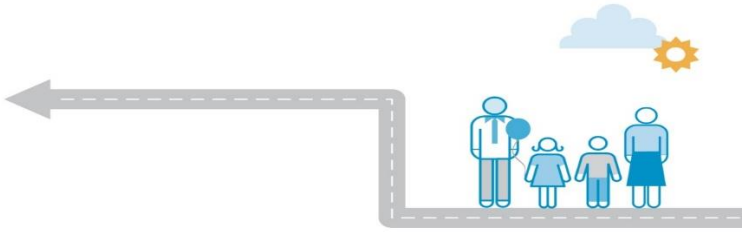

Quality Assurance Annual Report

2020 to 2021

Introduction

This report reviews the audit activity that has taken place between April 2020 to March 2021. Some adaptations have been made to the quality assurance framework and the auditing process due the unique circumstance of working in the changing environment of Covid-19. There has been more focus on thematic audits this year, rather than full case audits; this has allowed a more responsive approach to emerging needs.

As part of this report I will review the key finding from these audits, looking at the strengths and areas for future development, and how these findings will be incorporated into future learning and development of staff. A key area for learning from previous years has been the impact of auditing on managers and social workers. This year there has been a discernible move towards a more inclusive approach with managers and children's social care staff, which has proved to be a more positive and constructive approach.

Quality Assurance Activity

Thematic Audit on Face to Face and Virtual Visits Completed by Safeguarding and Quality Assurance Service Manager

May 2020

Thematic audits were completed on face-to-face and virtual visits that took place from the beginning of January 2020 to the end of April 2020. In total, 24 cases were reviewed from the Children's Social Care and Early Help Service. This audit reviewed how many visits took place during this time period, differentiating between whether they were face to face or virtual, and if they were virtual which method was used to contact the family.

The audit considered the detail of the information obtained and whether this was compromised by the method used. The purpose of the visit was also reviewed to assess if this had been achieved and if the child was seen / heard and visible in the recordings of the visit. Another area assessed was the ability to manage risk, especially in relation to child protection cases and new referrals.

Key Findings

- Overall, the majority of the cases reviewed showed a clear purpose to the visit and recordings were detailed and methodically laid out.

- When information was being obtained for the purpose of an assessment, headings such as health, education and wellbeing were clearly defined; this made it easier to understand family functioning.

- If the purpose of the visit was to convey information such as keeping safe during COVID-19, it was clearly identified and recorded that the young person understood the information being given.

- Where children were seen it was identified who was seen and whether they were seen on their own.

- The use of observational skills was also prominent in many of the recordings, which added a greater depth of understanding as to how the family were functioning.

- Where video contact was used with the family it gave more depth to the information recorded, with assurance in relation to risk and understanding a family functioning.

- Visits that took place over the phone presented as being more one dimensional in their content, whereby the flow of the conversation was fairly limited.

- There was also evidence of good observational skills, especially within the Early Help cases.

- The was evidence of direct work with children in Early Help cases, using the App “Mind of My Own” (MOMO).

Areas for learning & development

1) Virtual visits should define clearly what methods were being used to contact the family.

2) Telephone contact should not be the main form of virtual contact, as this does not give as much information as video contact.

3) Given the value that MOMO has added to virtual visits, consideration should be given to:

    a) Training and development of staff in using MOMO from the provider.
    b) Training session led by Early Help of how the App is used in practice.

4) Utilising evidence of good practice examples of virtual visits.

Full Case File Audits Completed by Aidhour, Independent Auditors

July 2020

A total of 12 cases (9 families) were audited. These cases came from a cross section of social work cases open to the Children's Social Care team and were identified by the Management Team. Audits were based on a review of the electronic case file and a discussion with the allocated worker and focused on social work intervention between January – July 2020.

Key Findings

Overall, the auditors identified that social workers knew and understood the needs of the children and families allocated to them by demonstrating commitment, enthusiasm and compassion when they were spoken to about the cases.

In the context of working under restrictions due to Covid-19, there was some good evidence of the use of technology to manage risk, support families and undertake direct work with children and families.

Management Oversight

There was evidence of timely and appropriate decision making on contacts and referrals. Cases that were stepped up to statutory services, or down to Early Help showed the rationale for the decision. Overall, there was good management oversight on the cases audited.

Practice

- There was evidence within assessments of a child focused approach in working with children and their families; this had led to responsive and creative plans to meet their needs.

- There is evidence in recordings, assessments, planning and interaction of a systemic approach being used when working with children and their families.

- Child Protection Conferences and Children Looked After Reviews are to a good standard. There was evidence that Child Protection Chairs and Independent Reviewing Officers have regular contact with children and young people outside of these formal meetings.

Areas for Development Practice

The audits identified that there were some good examples of appropriate and timely referrals onto partner agencies and organisations. However, auditors thought it would be helpful to have more updates on the progress of these referrals recorded on the child/young person's file.

1. Ensuring the views of absent parents, siblings and/or other significant family members are explored when completing an assessment so that there is a consistent level of high-quality assessments across all cases.

2. Questions around meeting threshold in “Child in Need” cases emerged as a theme in this audit. Management oversight in supervision and/or case discussions, exploring exit strategies around the impact of social work intervention would be helpful in evidencing threshold in these cases. This would also support more meaningful plans with child focused outcomes**.**

3. Where a case has had multiple allocations in a short period of time, there was evidence of drift and incomplete tasks. This highlights the importance of management oversight on the handover of cases, and the need to record this information on case notes on Mosaic.

Areas of Development Process

4. There were some process issues in regard to copying case notes onto another siblings file, in relation to relevance and keeping the recordings up to date. Which can have wider implications when someone unfamiliar with the case is looking at managing risk.

5. Improvements to the frequency and timeliness of holding supervision and uploading write-ups was identified as being an area where there needed to be improvements.

Practice assurance stocktake of contacts, referrals, and assessments

August 2020

In August 2020, an independent assurance stocktake was carried out on contacts, referrals and assessments by Chris Sands, Chair of the Achieving Excellence Board. The case selection for the stocktake was taken from all contacts, referrals and assessments between 01 July and 05 August 2020. In total, 25 contacts and referrals, and 5 assessments were reviewed. Of the 25 contacts, many were of multiple family members with one such example relating to 14 members of the same family.

The stocktake identified areas of excellent practice, but for the purpose of this report the focus will be on the key findings and areas for development identified from the stocktake.

Key Findings

Contact and Referrals

The overall quality of the response to contacts and referrals was identified as being good and demonstrated diligence, which remained consistent with findings in the Ofsted inspection in March 2020. Most contacts seen had timely and appropriate decisions made on them within 24 hours.

The majority of contacts the City of London receive were not connected to residents, but related to contacts from external agencies, predominantly regarding missing persons from other local authorities. The decision to take no further action was appropriate in all cases. The report identified that social workers were diligent in their approach in recording all national missing persons alerts. In one case they contacted the LA to say they had no information about an individual. However, to do this on every case would lead to a disproportionate amount of work.

In all missing persons alerts cases, the social worker recorded that the information had been sent to health agencies. This is good practice to ensure that no child falls between agencies. However, in most cases there was no evidence of this on Mosaic except in one case where this was confirmed by an email.

Management oversight of most contacts and referrals was routine and clear. The team manager took responsibility for the primary decision with the service manager doing a final check. This process provided for a robust oversight of decision making

Assessments

The quality of assessments overall was identified as being to a good standard. However, there were areas where, with further development, the quality could be improved further. A key area for improvement was showing evidence of curiosity in seeking to understand the workings of the family through the application of systemic thinking and practice.

The report also identified that in one case, the social worker had taken a sensitive approach, but this had not allowed the focus of the assessment to be compromised. There was good use of video calling, which complemented the direct visiting taking place. It was also identified that the management comments in relation to the case where thorough and demonstrated an understanding of the issues.

The stocktake recognised that some assessments would benefit from a more child-focused approach. This was highlighted in one specific case where a recommendation was made that consideration should have been given to what life was like for the child subject to the assessment. In respect of the same case, a recommendation was made that it would have benefited from remaining in the Early Help service, with regular consultation with Children's Social Care.

In some cases, not all the referral decisions for assessments included clear instructions as to what needed to be covered as part of the assessment, or expectations on timescales. A case example was given to highlight these comments, with additional comments about the importance of applying hypotheses and the rationale for these.

Management Oversight

The report recognised that although there was some good evidence of management oversight in some of the cases, this was not always consistent. If this were addressed, it would significantly improve the overall standard of management oversight.

Areas for development The report concluded with the following key areas that needed to be considered by senior leaders to improve practice.

- There was evidence that management oversight remains an area for improvement. Social work staff feedback was that managers did keep in touch on a regularly basis with practitioners. However, the records reviewed did not always demonstrate this.
- More focus should be given to evidencing reflection and hypothesis on what life is like for the child, combined with some more curiosity. Applying the systemic approach would help to cement excellent work in practice.
- The question was raised about whether there a policy for accompanying young people to placements. This arose from a case where an asylum-seeking young person was taken, unaccompanied, to a placement in a taxi. This could have presented a risk, had the young person run off during the taxi journey. Additionally, for a young person unfamiliar with this country, the journey could be quite frightening.
- Whether there was a policy and/or process map that clarifies practice expectations for the City of London's responses to missing persons alerts.
- Timely stepping down of cases to early help was a recommendation in the inspection report. The review identified one case where this was still an issue. This begged the query as to whether the tracking mechanisms in place were sufficiently robust.
- The stocktake also identified that planning had not yet been evidenced as being sufficiently robust; this was also noted in the Ofsted inspection report in March 2020.
- Records were not always being kept fully up to date. This was seen as being particularly important in the current Covid-19 situation, whereby staff are working remotely and needing to access records, perhaps in the absence of the allocated worker or for those working out hours.

Thematic Audits on Placement Stability

November 2020

Independent auditors commissioned to complete audits on quarterly basis as part of the quality assurances framework undertook a thematic audit on placement stability in November 2020. This followed concerns around placement stability which had been identified through performance data and the Independent Reviewing Officers annual report.

The thematic audit focused on identifying common denominators for moving from foster care to semi-independent accommodation, and how practitioners and commissioned services responded. The auditors reviewed 25 cases, reviewing the current cohort of 18 unaccompanied asylum-seeking children (UASC) which included four of the cohort of 12 multiple placement move cases identified in the annual report, with an additional 7 from that cohort who are no longer looked after. Each audit included an electronic case file review, interview with the allocated social worker (and manager if required), feedback from young people and their /carers/placements and, where possible and appropriate, feedback from previous carers/placements.

Impact of unresolved trauma and loss

Of the group of young people audited, the 8 young people who have been in foster care with the highest number of moves were all male and from Afghanistan, Sri Lanka, Eritrea, Sierra Leone and Sudan. All these countries have been or are war-torn, associated with which has been for some young people, directly experienced torture and witnessing the murder of family and friends. The four young people with the most placement moves, either had PTSD diagnoses, or were displaying strong indicators of trauma, having experienced traumatic loss including in the context of losing both parents to the Ebola epidemic, with the Covid pandemic triggering painful memories and feelings

Impact of Covid-19

For at least three young people, the impact of the Coronavirus pandemic and associated lockdown appears directly to have resulted in placement instability and breakdown. In one of these cases, it was associated with the young person going missing and remaining missing at the time of this audit. In another, it triggered painful memories of losing both parents to the Ebola epidemic.

Impact of immigration status uncertainty

Coinciding with the Coronavirus pandemic, this audit found an additional layer of anxiety for young people due to the delay in the Home Office progressing Substantive interviews which had been paused for young people as a result of the pandemic (Right to Remain Legal Update, 10th November 2020). Of the cohort of twenty-five young people with placement moves, all but three were awaiting their substantive interviews and associated immigration decision. The Key Worker of one of these young people aged 18, reflected; '*He can't get a job. He doesn't know when he will get his (substantive) interview and I think one impact for him is loneliness*'.

Wanting to move to London

Three of the eight young people with high numbers of placement changes identified a desire to be placed in London was the key pull factor in leaving placements – specifically, a desire to be close to an Orthodox Christian Church, and to live among people of the same nationality. Good transport links to facilitate easier access to college were also often cited in the case files

Desiring greater independence

A number of the cases reviewed illustrated clearly the challenge faced by the team of balancing the needs of some young people to be nurtured in a family environment but who possess an established level of independence, having had to look after, and make decisions for themselves in often hostile and uncertain circumstances in the absence of trusted adults. For some young people interviewed, their social workers have effectively become their secure base; in being empathic, non-judgmental and responsive, the social workers have become important attachment figures to the young people.

Impact of moves on education and mental health support

In experiencing the breakdown of placements, young people's college places or attendance were sometimes seen to be disrupted. One young person experienced five placements moves - every placement move also meaning a change of school/college, leaving his education disrupted. Placement moves have also, at times, impacted upon access to mental health and therapeutic support, which was clearly much needed by two young people in foster care.

Areas of Excellent Practice

Welcoming children who arrive during working hours: UASC children and young people who arrive during working hours are promptly seen and warmly welcomed by City of London Corporation Social Workers with the aid of interpreters. They are provided with City of London Corporation welcome packs, which are translated into the young person's language.

Short form age assessing: Where there is a question about the age of a young person, interviews for their short form age assessment take place on the day of arrival or soon after, providing opportunity for vulnerabilities to be assessed and responded to, as well as assessing age and most appropriate accommodation provision.

Relationships and support to young people

Social workers are mindful of the need to balance a nurturing approach with independence for unaccompanied asylum-seeking young people.

The quality of social worker relationships with children and young people is trusting, respectful, non-judgemental, honest, empathic, emotionally intelligent, responsive and proactive. This relationship was reflected in the social work recordings of visits and assessments, plans and reviews. City of London unaccompanied asylum-seeking young people were well understood and supported in their placement.

It is through the relationship with their social workers, that young people have been able to share that their placements have not been of good quality. Appropriate investigation of concerns is evidenced with appropriate outcomes. Review of placements with Supervising Social Workers are referred to in some of the cases.

Social workers can be seen to work collaboratively, proactively and tenaciously with key partner agencies, including statutory health and education providers as well as voluntary and charity sector organisations to secure help and support for their

children and young people. Collaboration with the London Asylum Seekers Consortium (LASC) was evidenced in two cases – and in one, impressively, to have directly led to a missing young person being found, through the links LASC had with the local community.

What some young people say about their social worker and their understanding of why they have a social worker

'I have a Social Worker because I don't have parents. My Social Worker helps me personally. She helped me with everything. She's very committed. She's done it. She's on it. She's done her best for me. I find her most interesting in that she understands the feelings of me - how I feel and how I think. She's being very supportive. I want to keep her; I said I want my Key Worker to be like her. She does support a lot. There is not a word to say how much she's supports! Every Social Worker I had supplied me 24/7 with City of London'.

Retaining timeliness, child focus and connection through technology and face-to-face during the Coronavirus pandemic.

There was good evidence of sensitive practice and child focused intervention, with excellent work by Social Workers. The use of technology to risk assess remotely and build rapport had been undertaken by workers with confidence and enthusiasm. Visits (direct and virtual) were completed within timescale and to a high standard. Social workers consider the child's world from their perspective, this is evidenced throughout case recordings.

Commitment to continuous improvement

City of London managers are committed to constantly reviewing and improving the knowledge, skills and confidence of their social workers to ever more effectively support their young people. Training from 'Waging Peace' a human rights, non-government organisation was specifically commissioned to raise social worker awareness of the Sudanese community and how most effectively to support their Sudanese young people who comprise a high number of their Looked After Children.

Timeliness of assessments and reports

The assessment, planning and review seen in files for the most part was timely and to a high standard. The quality of referral and contact forms continued to be good with timely and appropriate decision making evident. There was good evidence of management oversight and for the most part, assessments, plans and reviews were up to date.

IRO oversight of planning and review

There was evidence of good quality reviewing processes, with IRO footprint recorded on files in the lead up to and outside of formal meetings. Routine handover between IROs of young people was evident, as was their appropriate challenge and follow up with social workers and managers. It was apparent that young people felt able to reach out to their IROs.

Areas for Development

Welcoming and risk assessing new arrivals Out of Hours.

It was not clear that the children who had been supported by the shared Emergency Duty Team arriving out of core office hours had been met by a social worker upon arrival and prior to and during placing. This is a critical opportunity to assess immediate safeguarding, health and contextual risk concerns, including trafficking and exploitation to the young person and consider how they might most effectively be mitigated, and the child protected.

The recommendation therefore, is for consideration to be given to providing out of hours social work capacity to welcome, risk assess and contingency plan with providers or foster carers and police as needed, should they be at risk of, or go missing / be suspected victims, or at risk of modern slavery and human trafficking and to settle young people into their first foster or placement addresses.

Consistency of Assessments

Age Assessments

Where there is a question about a young person's stated age, 'short form age assessments' were found in some children's case notes of their Mosaic files. Fewer full age assessments were found, and their quality was found to be variable. Some were completed by independent social workers, and others by a combination of independent social workers and City of London social workers.

The recommendation is for a consistent format to be used, and for the age assessments to be uploaded into documents.

Children and Family Assessments, and Chronologies

The completion of Children and Family Assessments is seen to be increasingly consistent in 2020. In considering the circumstances of UAS children and young people specifically, it is **recommended** that as the likely key document in which their story is captured, empathically exploring pre-migration experiences in their country of origin including their environment to assist in assessment and planning; their journey to the UK and life in the UK, that Children and Family Assessments continue to be consistently completed. As circumstances change or new information comes to light they would usefully be reviewed and updated.

Risk Assessment

Risk Assessment' and 'Risk Management Plan' documents were found on some children and young people's files, but not all. It was not clear in what circumstances they were completed; how they were quality assured; the frequency of review; how they are RAG rated and if the rating links to other processes, such as strategy meetings; how risk assessments were tracked (for escalation or de-escalation of risk) or reviewed.

The recommendation is that guidance should be produced in collaboration with social workers and managers which considers all these points

Placement Plans

Placement Plans were found generally to be of high quality. In identifying issues which might disrupt placement stability, these are key documents outlining expectations of all.

The recommendation is that placement plans are consistently completed, whenever a young person changes placement, , with these placement plans being uploaded into children's files.

Consistency of location of forms, documents and agreements

Several documents were found to be uploaded in different parts of the child's file.

The recommendation is that the location of supervision notes, case summaries, chronologies and genograms should be uploaded into a consistent location.

Information sharing agreements were not in evidence in case files.

The recommendation is that an information sharing format should be developed and applied, consistently, to practice.

Line management clarity, Supervision and tracking processes

City of London Corporation Managerial footprint in the cases audited was apparent**.**

The recommendation is to strengthen supervision further by consistent and timely uploading of supervision notes and tracking of agreed actions from LAC Reviews, including referral to other agencies

Contextual safeguarding approach

As the majority of City of London Children are UASC many of whom live in semi-independent accommodation, they are likely to face risk primarily, from outside of the home.

The recommendation is that a greater focus and awareness relating to contextual safeguarding is required. This should be supported by a toolbox that includes multi-agency disruption responses to further develop how children, locations, people, businesses and organisations of contextual safeguarding concern can be identified.

Tracking children at risk

There was evidence in some of the case files audited of children's circumstances ranging from placement moves to sexually harmful behaviour being discussed at the 'Top Three' meeting, attended by City of London Managers and practitioners. It is understood that this meeting considers a variety of concerns and not solely safeguarding concerns.

The recommendation is made for consideration of this meeting, or allied meetings to regularly review the cases of children who are assessed to be medium or high risk of exploitation, or who are being exploited until such times as the risks to them are reduced.

Preparing for going missing

The City of London Police now routinely take photographs and fingerprints of UASC children presenting to them upon arrival and share the details with City of London Corporation. This is understood to be as part of the Operation Innerste which informs police response to UASC, recognizing them at point of arrival as potential victims of trafficking. A further complementary and beneficial development which would strengthen response further, evidence of which is yet be seen in case files, is the development of a 'planning for missing' process which would collate key information about vulnerable young people for police and be reviewed and updated as needed. It would ensure robust, detailed and timely coordination between foster carers, care providers, the City of London Corporation and Police Services in which children at risk of going missing are placed.

The recommendation is to develop a 'planning for missing' process which would collate key information about vulnerable young people for police and be reviewed and updated as needed.

Triple planning

Contingency planning associated with triple planning for UAS children and young people would benefit from development in the cases of the children whose files were audited. However much it is hoped that young people will remain in the UK, consideration has to be given to the possibility that a child may not be granted indefinite leave to remain; either voluntarily or involuntarily, they may face return to their country of origin.

The recommendation to support triple planning becoming embedded for City of London UASC, is that consideration should be given to Pathway Plan templates being developed to reflect the three possible outcomes.

Summary and Recommendations

This report outlines the quality assurance work that has been completed on frontline children's social care practice in the City of London over the past year. Consideration has been given to the impact of Covid-19 on practice in all the quality assurance activity that has taken place. There is considerable evidence that social workers and managers have been creative in using various methods of virtual and face-to-face contact when working with children and families over the past year.

There is also evidence of some excellent practice on the cases reviewed. However, this is sometimes not always consistent, and can be due to recordings not being up to date or process not being followed. The issues that have been identified are often easily rectified through adequate systems in place to ensure compliance. On the completion of the audits, the recommendations are shared with the social workers, managers and the service manager. They are either resolved immediately on a case by case basis, or if they are more systemic issues, they are included in the Service Development Plan. The Service Development Plan is updated on a regular basis by the Children's Social Care and Early Help Service Manager. There is oversight of

this plan from the Achieving Excellence Board and elected Members. Subsequent auditing tests whether the learning has been applied effectively to casework.

A key area of strength identified within all the audits has been the relationships that children and young people have with their social workers, who present as being responsive and supportive to the young people on their caseloads. The only problem that has been identified in this area is when there have been multiple changes of social worker. However, this does not appear to be occurring on a consistent basis and relates to a period earlier in the year when there were significant changes in staffing.

The audits completed throughout the year also identify areas of learning and development that would be helpful in improving practice. A key aspect of the Quality Assurance Framework is the training and development of staff, which followers the standards expected around Social Workers continued professional development (CPD), as identified by Social Work England. The key themes found in the audits completed in 2020/21 showed that contextual safeguarding and professional curiosity were areas that required more consideration when assessing risks and needs as part of the assessment process. This is not the first time that these two areas of learning have been identified from case file audits, therefore consideration does needs to be given as to the impact of learning on practice. At this current time, any learning that has been identified as part of the audit process would be either be progressed by the Children's Social Care and Early Help Service, or by the People's Learning and Development Service.

This raises the question around how we evaluate learning and development for children's social care staff in relation to relevance, quality and impact. In 2019, there was considerable investment in training for frontline staff on systemic practice. This has also been mentioned in some of the audits completed throughout the year, with differing views as to the impact on practice. Therefore, going forward, this is an area that does require further development, so we can ensure that staff are having the right training, which is at the right standard and is impactful on improving practice.

Pat Dixon

Safeguarding and Quality Assurance Service Manager

January 2021

Key Priorities identified for 2021/22

1. The Evaluation of Learning and Development Offer for Children's Social Care and Early Help Service, regarding feedback on content, impact and relevance.

2. Review and update work force development strategy.

3. Review the quality assurance framework to establish consistent criteria for evaluating practice.