Education, Children and Families Committee

10.00am, Tuesday, 22 May 2018

Child Protection Performance

Item number	7.9
Report number	
Executive/routine	
Wards	
Council Commitments	C34

Executive Summary

This report sets out progress made by CEC children's social work services in relation to key performance indicators; quality assurance work conducted in 2013-2017 and management of risk in child protection work.

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Report

Child Protection Performance

1. Recommendations

1.1 To note the content of the report.

2. Background

2.1 The performance of children's practice teams and the reviewing team in the council on day to day processes is measured against a number of key indicators including submission of reports to the Children's Reporter within timescale and the extent to which meetings such as Looked After Children's Reviews and Child Protection Case Conferences (CPCCs) are held within timescale.

2.2 The report describes performance in relation to these indicators and gives brief details on quality assurance work carried out within the children's social work service, the governance of Edinburgh Child Protection Committee and the operational multi agency procedure followed by senior managers to oversee the assessment and response to each new child protection concern.

3. Main report

Performance

3.1 There are no national comparisons for our processes – the only one previously available being the national comparison report from Scottish Children's Reporters Administration (SCRA) regarding Hearing Reports which stopped when SCRA moved to its new recording system. However, when last available, Edinburgh was well above the national figure (77% v 56%) and has continued to improve on this with the current year to date being 87% of Hearing Reports submitted within timescale.

3.2 Data indicates that overall performance has been maintained at a good level, but there have been variations over time and there were dips in some indicators between 2016 and 2017 which have been addressed by the management team.

3.3 Factors which have affected performance are changes to management arrangements (fewer middle managers in most, managing larger teams; fewer front line managers; and a high proportion of temporary managers in post for various reasons) and a reduction in business support in localities.

3.4 Nevertheless, overall performance remains good. Progress is reported by individual teams to the senior manager on a fortnightly basis and team performance is discussed with locality practice team managers in 1-1 meetings and actions are taken to address under performance. For instance, a trend of increasing numbers of late CPCCs was identified by the senior manager and a number of local measures taken has resulted in some improvement in performance which is visible in the data since then.

3.5 The service has reported separately to committee over the last 5 years on numbers of Looked After Children and the balance of care in the Looked After population. Corporate Parenting of Looked After Children is reported to the Corporate Parenting Member Officer Group and the service has put in place a champions board of Looked After Children and Young People whose views will inform planning and development of services. This work will be reported to a future Education, Children and Families committee.

Quality assurance of cases known to children's practice teams

3.6 In order to assess quality of practice in the service, there has been a range of quality assurance activity over a number of years. This has been done primarily in two ways:

- Case file audits
- Practice evaluation

3.7 Attached are a summary of quality assurance activity 2013-2017 and the findings of the most recent case file audit done in October 2017.

3.8 Cases file audits, including this most recent one, have shown an encouraging picture in relation to the extent to which day to day processes work and the extent to which staff records evidence the quality of the work they do.

3.9 Cases which are audited or evaluated are selected at random from the SWIFT social work recording system. It is therefore reasonable to assume that the findings of audits and practice evaluations are representative of standards of practice and recording across the service. Cases which are audited or evaluated may involve children who are looked after, subject to child protection procedures or children in need who are not subject to any formal legislative process or procedure.

3.10 The analysis of strengths and areas for development inform planning for the service. Current development priorities include increasing the quality of chronologies and an in-house training course has been designed and delivered by our Workforce Learning and Development team.

Edinburgh Child Protection Committee

3.11 Edinburgh Child Protection Committee (ECPC) is the multi-agency partnership which drives improvement in child protection through an agreed Child Protection Improvement Plan (CPIP). The Child Protection Committee reviewed the CPIP at an away day on 14 March 2018 and it is currently being updated.

3.12 ECPC reports to a Lothians-wide multi agency Chief Officers Group which is chaired by the CEC Chief Executive.

3.13 ECPC commissions independently chaired reviews of significant cases in which harm has occurred to children. One such case review reported in 2017 and there is a further review which will conclude in the current year. The 2017 report related to historical sexual abuse of children looked after in CEC residential care in the period from 1994-2006. The review team invited the committee to consider a number of questions in relation to listening and taking into account the lived experiences of children in our care; quality of investigative processes; quality of care and staff recruitment processes. The council's quality improvement team has undertaken work in relation to each of these areas which is in the process of being converted into an action plan by senior managers. This will be reported in the first instance to the Chief Officer Group for Public Protection chaired by the Chief Executive.

Senior officer scrutiny of child protection work

3.14 There is a high level of senior officer scrutiny of child protection work at individual case level. Agencies work closely together in the day to day operations of child protection and senior officers are closely involved in jointly authorising the actions taken. Since 2011 we have had in place the electronic IRD (eIRD) which is a shared electronic record for Inter Agency Referral Discussion (IRDs). An IRD is the multi- agency conversation which takes place between statutory agencies (police, NHS and social work) when a child protection concern is received. Its purpose is to agree a multi-agency assessment of risk, determine what measures are necessary to investigate the concerns raised, agree immediate measures if required to protect the child, and agree whether a Child Protection Case Conference (CPCC) is needed in order to make a Child Protection Plan. Each eIRD is reviewed by a meeting of senior officers and no IRD is closed without agreement of the senior officer in each statutory agency.

3.15 These arrangements ensure robust senior level decision making in relation to each child protection concern.

Elected Member Involvement

3.16 There is currently no elected member involvement in the governance of child protection work. It is proposed to address this by inviting member representation onto the Chief Officer Group (COG). This first needs to be discussed with the COG before referring to Corporate Policy and Strategy Committee.

4. Measures of success

4.1 Key performance indicators.

4.2 Findings of case audits and practice evaluations.

4.3 Outcomes achieved as per child plans agreed on an individual basis for children.

5. Financial impact

5.1 The service managed pressures on out of council placements in 2017-18. A review of CEC residential care will be conducted in 2018-19 to ensure that provision is proportionate to demand.

6. Risk, policy, compliance and governance impact

6.1 Operational risk is managed through adherence to multi agency child protection procedures.

7. Equalities impact

7.1 Children's practice teams and multi-agency child protection services work to meet need and manage risk for the city's most vulnerable.

8. Sustainability impact

8.1 None.

9. Consultation and engagement

9.1 The service has set up a champions board for looked after children to engage and participate with officers and elected members in our corporate parenting work.

10. Background reading/external references

10.1 Child Protection and Looked After Children Performance

10.2 Case File Audit – Social Work Services, Communities and Families - Single Agency, October 2017

10.3 Document of QA work and Key Findings, Children's Services 2013 – 2017, Strengths & Areas of Development

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11. Appendices

11.1 None.

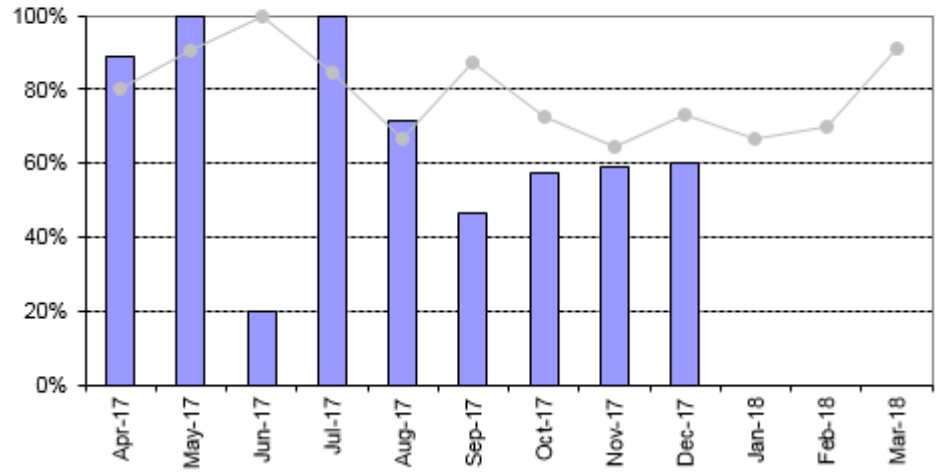
Child Protection and Looked After Children Performance

Note: the grey line shows the monthly figures for the previous year.

All data is up to December 2017.

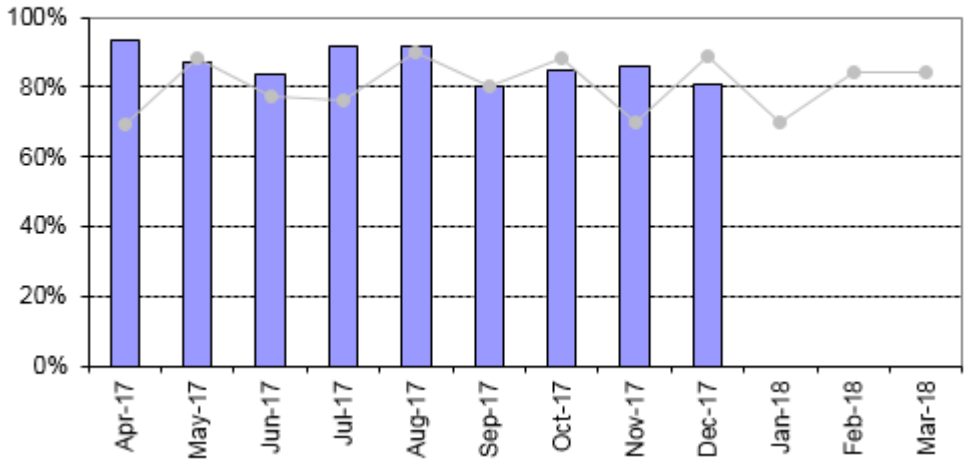
The following two indicators are reported through the Children's Services Monthly Report.

Percentage of children seen by a supervising officer within 15 working days in 2017-18 by month



Year to date 2017/18 = 64%. 2016/17 = 81%

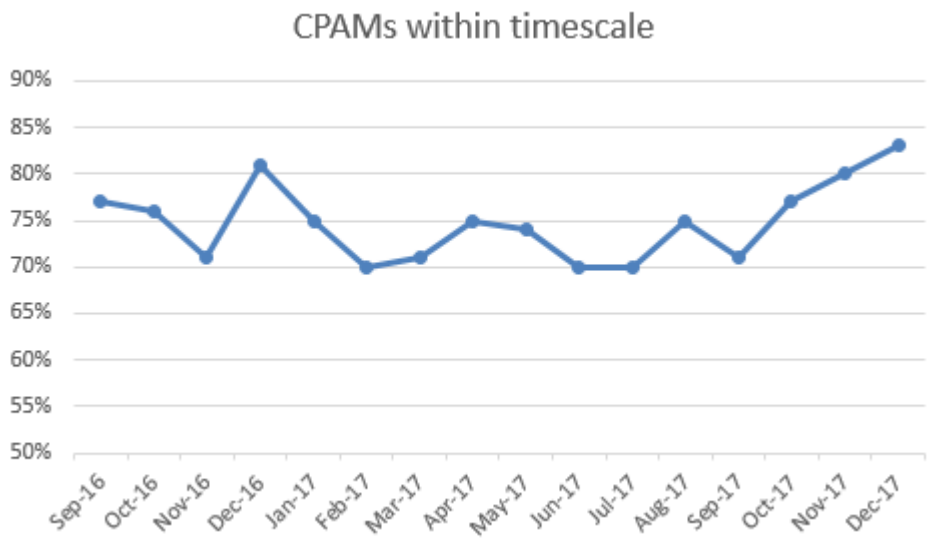
The percentage of Children's Hearing reports requested by the Reporter which were submitted within target time in 2017-18 by month



Year to date 2017/18 = 87%. 2016/17 = 80%

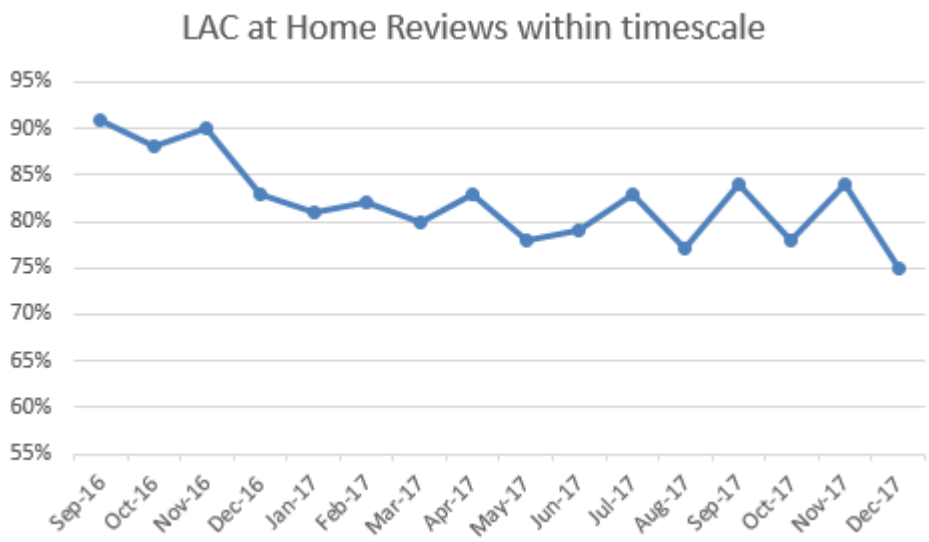
The following two indicators are reported through the Children's Services Fortnightly Report.

Care Planning and Agreement Meetings (CPAMs) within timescale



Range over last 12 months is 70% to 83%. Current figure is 83%.

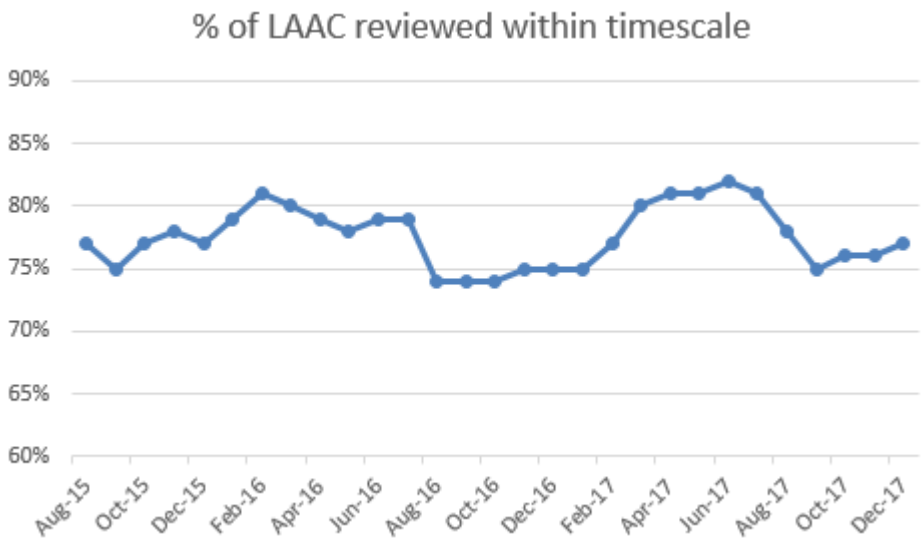
Current Children Looked After at Home reviewed within timescale



Range over last 12 months is 75% to 84%. Current figure is 75%.

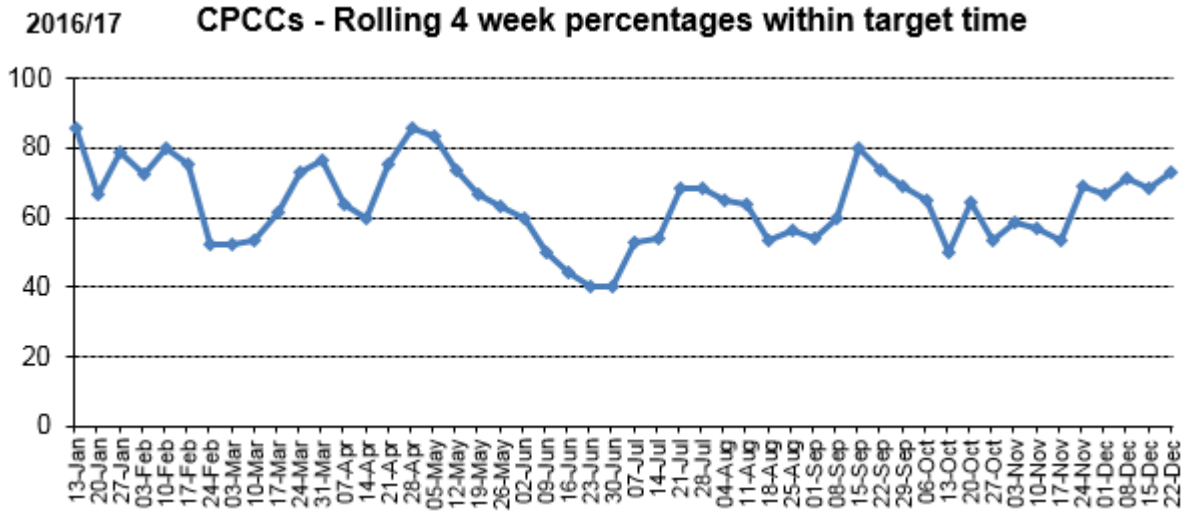
The following two indicators relate to the Children and Young People's Review Team.

Current Children Looked After and Accommodated reviewed within timescale



Range over last 12 months is 75% to 82%. Current figure is 77%.

Child Protection Case Conferences held within timescale

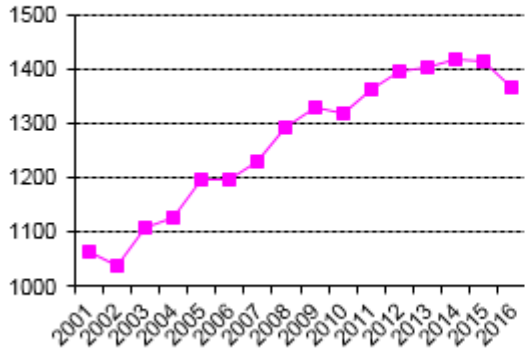


Range over last 12 months is 40% to 86%. Current figure is 73%.

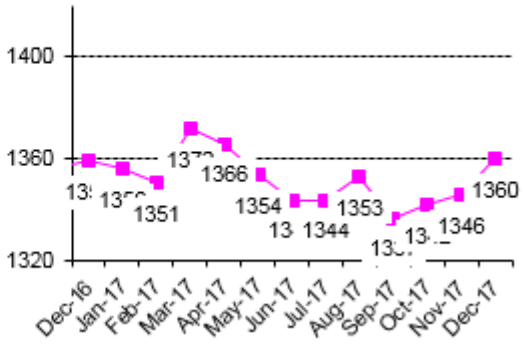
The Looked After Children population and the Balance of Care

The number of Looked After Children

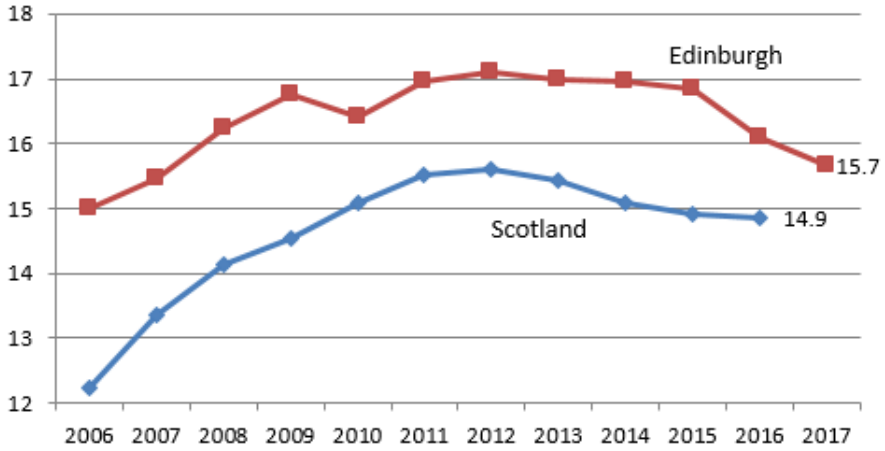
Historical trend 2001 to 2016



Recent trend

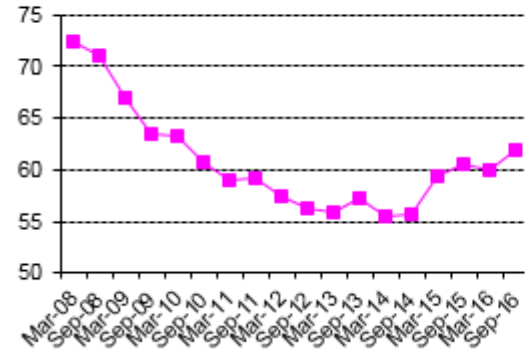


Looked After Children as a rate per 1,000 population

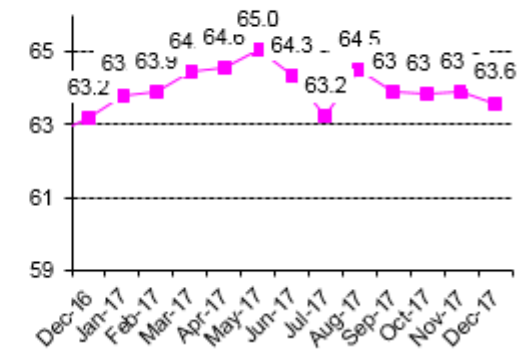


The percentage of Looked After Children in Foster Care that are placed with Council carers

Historical trend March 2008 to September 2016



Recent trend



The rate per 1,000 LAC and % with CEC carers are currently both included in the Performance Dashboard for the Corporate Leadership Team.

Case File Audit – Social Work Services

Communities and Families - Single Agency Case File Audit

October 2017

1. Background

1.1 The Case File Audit Programme is part of a Quality Assurance Framework to monitor and improve departmental performance. It allows the department to self-evaluate practice and determine:

- how well day-to-day processes work;
- how well staff evidence the work they do through good quality record-keeping.

1.2 The Community and Families Management Team requested a single agency 100 case file audit to review the quality of Assessments of Need and Risk (ANRs). The audit was completed in October 2017.

1.3 The case file audit followed feedback on the quality of ANRs in September 2016 from members of the Children's Panel and Reviewing Officers from the Children and Young People's Review Team. Briefing and guidance sessions were subsequently provided to staff at team meetings, with the aim of improving the quality of ANRs, and this training was delivered to localities between the end of 2016 and July 2017.

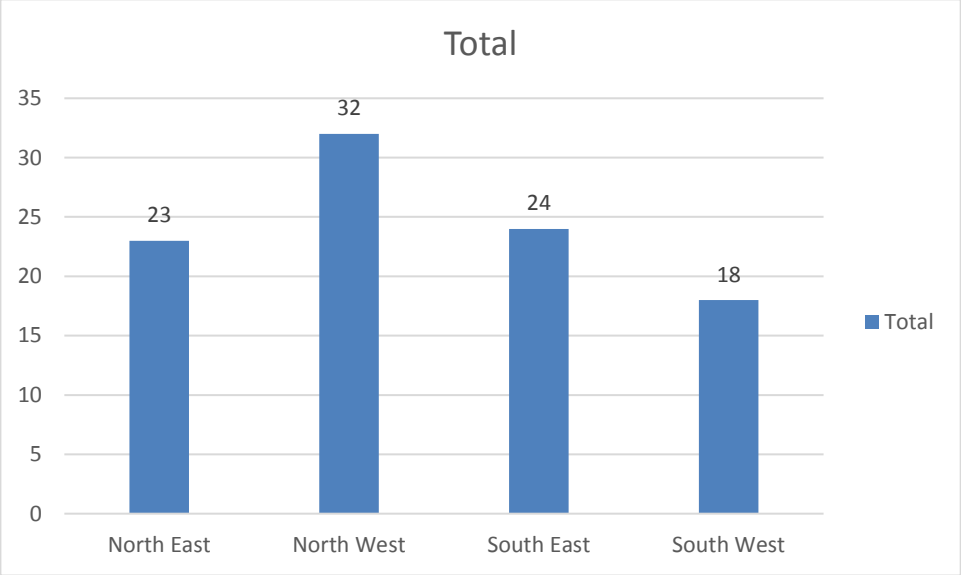
1.4 The main purpose of the 2017 case file audit was to review the impact of the briefing sessions and assess the quality of current practice. Where applicable, comparisons have been made with findings from the last audit in 2016, which reviewed 100 cases (90 on a single agency basis). This audit focused on targeted areas of development resulting from previous case file audits over the period 2011 to 2014.

1.5 As per the 2016 audit report, additional analysis will be provided for sampled child protection cases. This will highlight any variations.

2. Methodology

2.1 The 2017 case file audit intended to produce findings from 100 case file readings. However, the final return of audited cases totalled 97, and as such, this report will focus on findings and analysis from these 97 cases. Cases were selected from each of the four localities and audited on a single agency basis. Figure 1 shows a breakdown of the number of cases audited for each locality:

Figure 1: Cases Per Locality



2.2 The cases sampled for the 2017 audit were selected at random using the following criteria:

- cases with an ANR completed in June, July or August 2017;
- child protection (initial or pre-birth case conference), initial / review children's hearings and cases involving de-registration from the child protection register.

2.3 Whilst it was intended to choose a sample breakdown of 25% child protection and 75% looked after and accommodated children's cases, this was not possible due to the availability of completed ANRs within these categories during the designated period. As a result, the breakdown of the 97 reviewed cases was as follows: child protection (34 cases, 35%); child in need (6 cases, 6%); LAAC (57 cases, 59%).

2.4 26 internal case file readers (Senior Practitioners, Team Leaders and Practice Team Managers), were assigned to read electronic case files over a designated two-week period, with the results recorded on survey monkey.

2.5 Briefing sessions were offered to readers on three separate dates, 29 August, 30 August and 4 September. The purpose was to provide uniformity of understanding in relation to scoring / rating the files audited. The sessions were not mandatory and were attended by 42% of readers. File reading guidance notes, specific to the 2017 audit, were also provided to all readers prior to the case readings (see appendix 1).

2.6 The questions were developed between Communities and Families and Quality Assurance. Relevant questions from the 2016 case file audit were included, to allow for some comparative analysis and reporting between the 2016 and 2017 audits. Please note that the 2016 audit was completed using an amended version of the former Social Work Inspection Agency (SWIA) case file audit tool.

2.7 The audit was co-ordinated by the Quality Assurance Service. The audit focused on key areas of the ANR which included the quality of chronology, quality of assessment and recommendations, effectiveness of the child's plan, recording of views of the child / parent / carer, and multi-agency working.

2.8 The survey monkey format allowed readers to answer or skip questions which has, for some questions, reduced the number of responses.

3. Findings

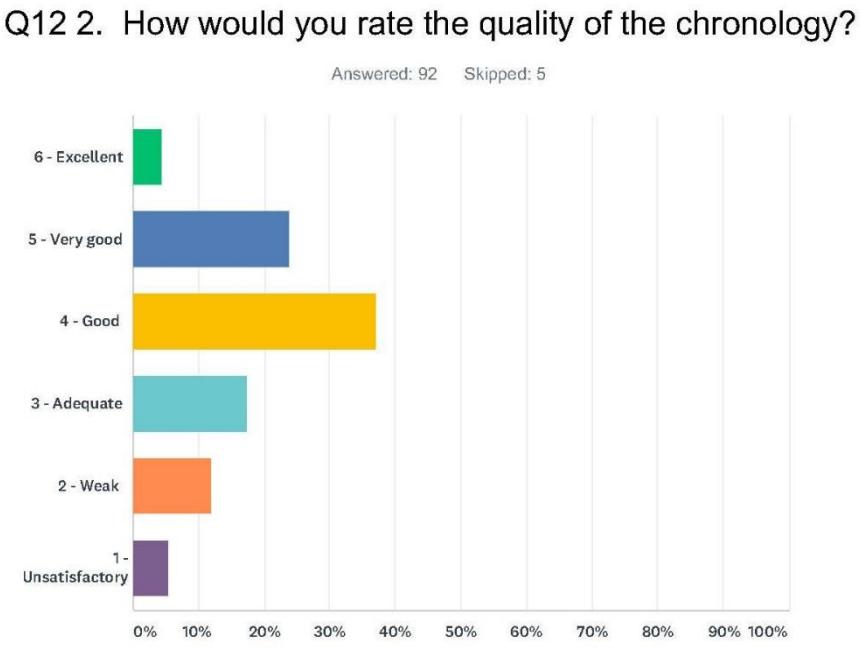
3.1 Chronology

3.1.1 Where appropriate, a chronology was attached to the assessment in 90% of the audited cases. There was no chronology found in 10% of cases, although in 4% of those cases, readers explained that a chronology was not expected.

For the child protection cases sampled, 88% had a chronology.

3.1.2 Readers were asked to rate the quality of the chronology using a prescribed scale (Excellent, Very Good, Good, Adequate, Weak, Unsatisfactory) as set out in appendix 1. Figure 2 outlines the findings.

Figure 2: Quality of the Chronology



ANSWER CHOICES	RESPONSES	
6 - Excellent	4.35%	4
5 - Very good	23.91%	22
4 - Good	36.96%	34
3 - Adequate	17.39%	16
2 - Weak	11.96%	11
1 - Unsatisfactory	5.43%	5
TOTAL		92

3.1.3 Chronologies rated as excellent and very good (28%) had similar characteristics with readers commenting: ***relevant information recorded, succinct, clearly outlined action / interventions, evidenced based, up to date and clear picture***.

Chronologies rated good (37%) contained most of the relevant information but comments such as: ***too long, evidence of copy / paste and out of date information were made***.

Chronologies rated adequate, weak and unsatisfactory (35%) shared similar characteristics: ***no chronology, too detailed, difficult to understand, use of copy / paste, use of abbreviations, missing pertinent information and out of date***.

Of the child protection cases sampled, none had chronologies rated as excellent, 9% were rated as very good, 41% good, 23% adequate, 15% weak and 12% unsatisfactory (from the sample of 34 child protection cases).

3.2 Assessment of Need and Risk

3.2.1 The timing of the completion of the ANR was rated as in keeping with the needs of the service user in 100% of the cases read.

3.2.2 85% of the assessments were rated as proportionate to the apparent level of risk and need from the chronology and case records. The following themes were identified**: *clearly identifies risk, makes clear recommendations, good level of analysis, clear plan***.

In the 15% of cases where the assessment was not considered proportionate, the following reasons were given: ***assessment lacks analysis, clear picture not provided, assessment does not reflect case records, assessment does not clearly outline risk, lack of evidence, lack of chronology, too detailed***.

71% of the child protection cases sampled were rated proportionate to the apparent level of risk and need from the chronology.

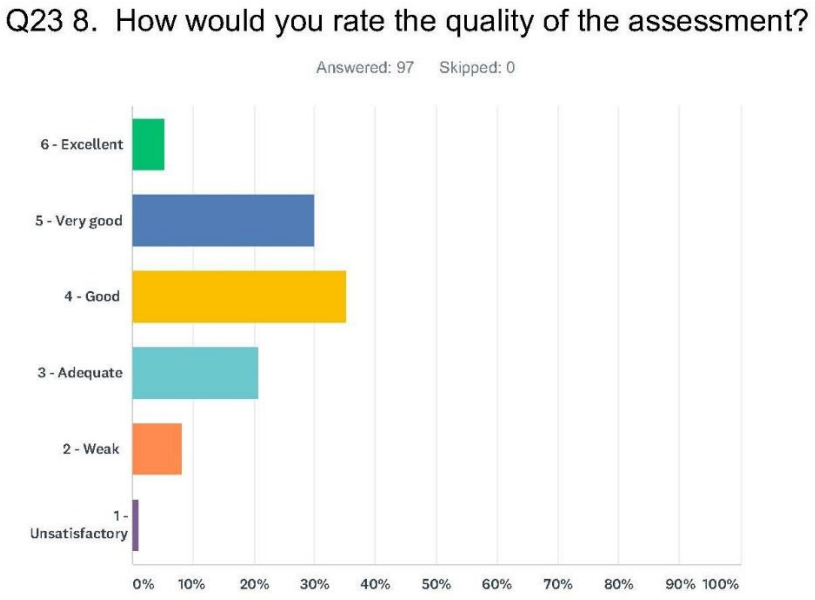
3.2.3 82% of cases had information documented in the assessment which was up to date. Readers commented that ***historic information relevant to the current situation had been retained and the assessment focused on the current situation with relevant historical information contained in the chronology***.

In 18% of cases, readers found the information to be out of date or overly historic. In these cases, the following themes were identified: ***more summary of historic information required, more reference to chronology required, out of date irrelevant information, copy / paste used, over summarising affecting clarity***.

85% of the child protection cases sampled contained information which was up to date.

3.2.4 Readers were asked to rate the quality of the assessment using a prescribed scale (Excellent, Very Good, Good, Adequate, Weak, Unsatisfactory) as set out in appendix 1. Figure 3 outlines the findings.

Figure 3: Quality of the Assessment



ANSWER CHOICES	RESPONSES	
6 - Excellent	5.15%	5
5 - Very good	29.90%	29
4 - Good	35.05%	34
3 - Adequate	20.62%	20
2 - Weak	8.25%	8
1 - Unsatisfactory	1.03%	1
TOTAL		97

3.2.5 Assessments rated as excellent and very good (35%) shared similar characteristics: ***clear risk statement, good analysis of patterns, clear plan, child centred, clear recommendations, well written, guided by ANR guidance document*.**

Assessments rated as good (35%) generally ***contained the relevant information but would have benefited from more analysis***.

Assessments rated as adequate and weak (29%) shared similar characteristics: ***overly narrative, lacking analysis, limited record of child views or views of other key people / partner agencies, lacking clarity, excessive copy / paste, alternatives not explored, missing pertinent information, assessment not specific to the child***. 1% of assessments were rated as unsatisfactory. This assessment did not provide: ***a clear picture about the child, there was no analysis, the chronology was out of date and the recommendations made were not justified***.

Of the child protection cases sampled, none of the assessments were rated as excellent, 29% were rated very good, 27% were rated good, 29% were rated adequate, 12% weak and 3% were rated unsatisfactory (from the sample of 34 child protection cases).

3.2.6 77% of the cases had a good summary of concerns, needs and risks at the beginning of the assessment. The following comments supported this: ***assessment distinguishes between risk and need, provides a good summary, succinct, good analysis, clear picture, identifies patterns***.

In the 23% of cases where the summary was not considered to be of a good standard, readers commented: **incorrect form used, too lengthy, lacks clarity, lacks analysis, contains inaccuracies, section not completed, missing pertinent information, out of date information, overly generalised, cut and paste used.**

71% of child protection cases sampled were found to have a good summary of need and risk at the beginning of the assessment.

3.2.7 In 80% of cases, readers confirmed that recommendations were clear, realistic, justified and alternatives considered. The following themes were identified: ***clear justification / evidence, clear explanation of alternatives explored, clear recommendation, recommendations reflected in child's plan***.

In 20% of cases where the recommendations were not of the expected standard, readers commented: ***lacking evidence for recommendation, alternatives not explored, no recommendation made, recommendation not relevant to assessment*.**

78% of child protection cases sampled had evidence of recommendations which were clear, realistic and alternatives considered.

3.2.8 74% of cases evidenced that the views of the child / young person had been sought and recorded in the ANR (with pre-birth case conference cases excluded), as appropriate to their age and stage of development. Readers commented: ***workers had engaged with the child / young person to seek their views and talk through plans, where possible, including these in recommendations***. For cases of very young children and babies, readers commented: ***workers made observations of the child's attachment, responses and behaviour and recorded this in the assessment***.

However, 26% of cases did not evidence the views of the child / young person in the assessment. The main reason for this appears to have been due to the young age of the child and readers commented: ***where the child did not yet have verbal skills, the assessing worker should have provided some analysis of the child's presentation, behaviour and responses, particularly for example, where contact sessions had been observed with the parents or visits made to the carer***.

74% of child protection cases sampled evidenced that the views of the child / young person had been sought and recorded in the ANR as appropriate to their age and stage of development.

3.2.9 93% of cases were found to have an assessment which reflected the views of the parents / carers. Many readers commented that these views were clearly recorded in terms of planning and recommendations. However, in 11% of these cases, readers added that a view had not been obtained from both parents, or where it had, the detail was too brief and limited. In the remaining 7% of cases, readers clearly felt a parental / carer view was not reflected in the assessment with comments including: ***no up-to-date view recorded; no record of father's view; and parental engagement sought but not achieved***.

88% of the child protection cases sampled reflected the parent / carer's view in the assessment.

3.2.10 In 90% of cases, the relevant partner agencies were found to be actively involved in the assessment. Many readers commented that ***the assessment reflected information shared by the police, education, and health and that the expectation of their roles and responsibilities towards planning was clearly recorded***. This was not the position in 10% of the cases, with readers' comments indicating a ***lack of recorded detail to explain how the different agencies were working collaboratively together***.

85% of the child protection cases sampled evidenced the involvement of relevant partner agencies.

3.3 Child's Plan

3.3.1 A child's plan was available in 95% of the cases and considered to be fully proportionate to the level of risk and need in 76% of these cases. The following comments were made in support of these findings: ***clear plan, clear actions, clear accountabilities, child centred, holistic***. The child's plan was rated as partially proportionate in 15% of cases and not proportionate in the remaining 9% of cases. These responses identified similar themes: ***lack of detail, out of date, not holistic, no plan / plan not complete, lacks clarity of expectation / accountability, lacks focus on identified risks, out of date***.

The child protection results reflected the overall findings regarding the availability of the child's plan, with one being available in 94% of cases. However, 70% of the child protections plans were considered fully proportionate to the level of risk and need.

3.3.2 In 74% of cases, the child's plan was written in Specific, Measurable, Achievable, Realistic, Timebound (SMART) format. Readers were only asked to provide a written comment where they had answered no to this question. The following themes emerged: ***plan lacks specifics, no timescales, out of date, lacks structure, overly complex, incomplete, lacks focus, not reflective of assessment, key people not partners to plan.*** However,

several readers in the comments section stated that they would have answered "partially" had this been an option.

74% of the child protection cases sampled were also written in SMART format.

3.3.3 The child's plan was rated as child focused in 78% of the cases. Readers were only asked to provide a written comment where they had answered 'no' or 'partially' to this question. 6% answered no and 16% answered partially. Readers answering 'no' did so because: ***no plan was included, plan lacked detail***. The following themes emerged from the partial responses: ***lacks sufficient links to the child and too general***.

70% of the child protection cases sampled found the child's plans to be child focused, 24% were partially and 6% were not.

3.3.4 In 87% of cases, the plan made clear the expectations of parents / care givers in order to improve outcomes for the child. Readers found that ***these plans were clear and set out desired outcomes, timescales, and roles / responsibilities***.

84% of the child protection cases sampled found the plan made clear the expectations of parents / care givers in order to improve outcomes for the child.

3.3.5 79% of cases had evidence of relevant agencies contributing proportionately to the plan. Some readers commented that whilst partner agencies were named, it was not clear from the case notes, assessment, or child's plan what their specific roles and responsibilities were and what support they were actively providing towards the plan. In 4% of cases, readers commented that there was no clear or comprehensive plan available to review.

71% of the child protection cases sampled had evidence of partner agencies contributing to the plan.

3.4 Delivery of Positive Outcomes

3.4.1 88% of cases evidenced that appropriate action was being taken to facilitate positive outcomes for the child / young person. Evidence of positive outcomes included: ***appropriateness of placement, good levels of support, plans being adapted to changing needs and risks, and safe contact / effective working arrangements with family members***. In the 12% of cases where this was not found to be the position, readers stated this was either because ***no plan existed or the plan was not clear / concise and lacked sufficient detail***.

79% of the child protection cases sampled found evidence that appropriate action was being taken to facilitate positive outcomes.

3.4.2 In a free text section of the survey, readers were asked to comment on what was making the difference / impacting on the delivery of positive outcomes. 83% gave positive examples: ***effective multi-agency working, early intervention, clear concise plan, good engagement, access to resources, stability of care, child focused plans and quality of assessment***. 17% provided examples of barriers to positive outcomes: ***lack of engagement and lack of specifics in the plan making monitoring difficult***.

3.5 Written Quality of Assessment

3.5.1 Readers were asked to comment on the quality of grammar. Cases assessed as excellent, very good or good (91%) shared similar themes: ***well written and organised, concise information, clear use of language, abbreviations were always written out in full first***. 7% of cases were rated as adequate and 2% were assessed as weak, with no cases found to be unsatisfactory. The cases rated as weak were due to: **incorrect punctuation, poor use of grammar and sentence structure, and dates not being written in the council approved format**.

Of the child protection cases sampled, the quality of grammar was as follows: excellent / very good / good 88%, adequate 9%, weak 3%.

3.5.2 65% of cases had assessments which were clear / focused and concise. 28% of cases partially met this as readers found these ***assessments lacked analysis and focus, had no clear recommendation, were not detailed enough, had chronologies which were too long, used irrelevant information, contained too much reference to historical events, and had significant details missing***. In 7% of cases, readers found that the assessments were not clear / focused and concise. The reasons given for this were: ***disjointed, too long and lacking focus, too much information and detail, no analysis of risk to clearly inform recommendations***.

Of the child protection cases sampled, 62% of cases had assessments which were clear / focused and concise. 32% of cases only partially met this, and 6% of cases were not considered clear focused and concise.

3.5.3 Use of copy / paste was found to be an issue in 25% of cases, with 12% of cases having at least partial evidence of this practice. Readers stated this was evident due to things like: ***out-of-date sibling information being contained within the assessment, duplication of information, chronology containing copies of email communication, different styles of grammar used, use of past and present tense, copying from case records and inappropriate sentence structure (i.e. sentences not ending properly)***.

Use of copy / paste was found to be an issue in 35% of the child protection cases sampled, with 15% of cases having at least partial evidence of this practice.

3.5.4 20% of cases were found to have unnecessary duplication of information. Readers commented on ***the duplication of information between different sections of the report and mentioned the same information being contained within the main report and chronology***. Some readers stated that ***too much historical information was in sections like the summary of concerns*.**

12% of cases were found to have unnecessary duplication within the child protection sample.

3.5.5 The use of abbreviations, jargon or the names of people and services without an explanation was found to be an issue in 34% of the cases reviewed, with 18% having at least partial evidence of this practice. ***The use of acronyms for names of services, processes and meetings; and references to people without a clear explanation as to their position within the family structure were highlighted as the main issues***.

The use of abbreviations, jargon or names of people and services without an explanation was found to be an issue in 38% of the child protection cases sampled, with 24% having at least partial evidence of this practice.

4. Analysis of Results

In order to analyse the findings of the case file audit a general threshold of 80% was set by quality assurance officers in order to measure areas of strength. As the child protection sample was smaller than the overall sample, a natural variation of 2% has been allowed. Therefore, child protection cases with a score of 78% or 79% have still been considered as an area of strength.

4.1 Areas of Strength

4.1.1 In the current audit, the timing of the completion of the most recent assessment of risk and need was in keeping with the needs of the service user in 100% of the cases. This had increased from 90% in the 2016 audit.

Child protection remained at 100% in both audits.

4.1.2 93% of cases were found to have an assessment which reflected the views of the parents / carers.

88% of the child protection cases sampled reflected the parents / carers views in the assessment.

There is no comparative data available from previous audits.

4.1.3 82% of cases had information documented in the assessment which was up-to-date and relevant.

85% of the child protection cases sampled contained information which was up-to-date and relevant.

There is no comparative data available from previous audits.

4.1.4 90% of relevant partner agencies were actively involved in the assessment, no change from the 2016 audit.

For child protection cases sampled, this was 85%, down 11% from the 2016 audit.

4.1.5 80% of cases had recommendations which were clear, realistic, justified and alternatives considered.

78% of the child protection cases sampled had recommendations which were clear, realistic, justified and alternatives considered.

There is no comparative data available from previous audits.

4.1.6 90% of assessments had a quality of grammar deemed to be of a good standard or higher.

The grammar was of a good quality or higher in 88% of the child protection cases sampled.

There is no comparative data available from previous audits.

4.1.7 87% of plans were found to make clear what was expected of parents / carer to improve outcomes for children / young people. This represented no change from the 2016 audit.

For child protection cases sampled, this was 85%, which was a 10% decrease from the 2016 audit.

4.1.8 88% of cases evidenced that appropriate action was being taken to facilitate positive outcomes for the child / young person. This was a significant increase of 19% from the 2016 audit.

For child protection cases sampled, the figure was 79%, a decrease of 8% from the previous audit.

4.2 Development areas

4.2.1 The current audit highlighted that 90% of assessments were found to have a completed chronology, a 3% increase from the 2016 audit. However, the quality of the chronology was considered to be of a good standard or above in

65% of the cases sampled. This is considered an area of development due to the quality of 35% of the chronologies sampled.

A completed chronology was identified in 88% of the child protection sample, a 3% decrease from the 2016 audit and a 12% decrease from the 2013 audit. However, the overall quality of the chronology was only considered to be of a good standard or above in 50% of the child protection sample. 80% of the cases rated as unsatisfactory from the overall sample were child protection cases.

4.2.2 In the current audit, 85% of the assessments were rated proportionate to the apparent level of risk and need evident from the chronology and case records. This is a decrease of 15% from the 2016 audit. The quality of the assessment was considered to be of a good standard or above in 70% of the cases sampled. This is considered an area of development due to the quality of 30% of the assessments sampled.

In the current audit, 71% of child protection cases had an assessment proportionate to the apparent level of risk and need evident from the chronology and case records. This is a decrease of 29% from the 2016 audit. The overall quality of the assessment was considered to be of a good standard or above in 56% of the child protection sample.

4.2.3 77% of cases had a good summary of concerns, needs and risks documented at the beginning of the assessment.

For child protection cases sampled, this was 71%.

There is no comparative data available from previous audits.

4.2.4 The child's view was recorded, appropriate to the age and stage of the child / young person, in 74% of the overall sample. This was a 2% increase from the 2016 audit.

For child protection cases sampled, this was also 74%, down 13% from the 2016 audit.

4.2.5 Whilst the written quality of the assessment was found to be good or above in 91% of cases, the use of abbreviations was found to be an issue in 34% of cases and 25% had evidence of copy and paste. 20% of cases had unnecessary duplication of information.

For child protection cases sampled, the use of abbreviations was found to be an issue in 38% of cases, copy and paste in 35% and unnecessary duplication in 12%.

There is no comparative data from previous audits.

4.2.6 95% of cases had a child's plan, a 7% increase from the 2016 audit. However, 76% of these cases had a plan considered to be proportionate, a 20% decrease from the previous audit. Although the current audit considered 15% of the remaining child's plans to be 'partially' proportionate, the comments made were similar to those where the plans were not considered to be proportionate. See 3.3.1 for more details.

For child protection cases sampled, 94% had a child's plan, a 1% decrease from the 2016 audit. However, 70% had a plan considered to be proportionate, a 25% decrease from the previous audit. A partial option was given in the 2017 audit which was not previously available and 23% selected this option.

4.2.7 74% of cases had a child's plan which was written in SMART format. This was a slight decrease from the 2016 audit (76%).

This was the same for the child protection cases sampled.

4.2.8 In the current audit, 78% of the cases had a child's plan which was child focused.

For child protection cases sampled, the plan was child focused in 70% of cases

There is no comparative data from previous audits.

4.2.9 79% of cases were found to have relevant agencies contributing proportionately to the plan.

For child protection cases sampled, this was 71%.

There is no comparative data from previous audits.

5. Conclusions

5.1 Areas of strength

5.1.1 It is positive that the 2017 case file audit found strength in the following areas (within the overall sample and within the child protection sample): the timing of the completion of the assessment *(4.1.1)*; the written quality of the assessment *(4.2.6)*; the recording of parents views in the assessment *(4.1.2);* the recording of up-to-date information in the assessment *(4.1.3)*; the recording of the involvement of relevant partner agencies in the assessment *(4.1.4)*; the clarity of recommendations *(4.1.5)*; the standard of the written quality of the assessment *(4.1.6);* the clarity of expectations for parents within the plan *(4.1.7);* and evidence of appropriate actions to facilitate positive outcomes for the child / young person *(4.1.8)*.

5.2 Development areas

Although the remainder of the conclusions focus on areas of development, it is worth noting that the case file audit found more evidence of good practice than practice which did not meet the required standard.

5.2.1 Despite there being an increase in the number of chronologies completed, the audit findings show that 35% were below a good standard. For the child protection cases sampled, the figure was lower still at 50%. *(4.2.1)* Given the importance of the chronology in highlighting trends for practitioners, managers, panel members and reviewing officers (and arguably more importantly the allocated worker), the findings are an area of concern overall and particularly within the child protection cases sampled. Whilst the briefing sessions provided to the practice teams touched on this area, it is evident from the findings that more action is required to lift the standard of chronologies.

5.2.2 The number of assessments deemed to be proportionate to the level of risk and need has decreased *(4.2.2)*. This was of particular concern within the child protection cases sampled, with 29% of the assessments not being considered proportionate to the level of risk and need *(4.2.2)*.

The quality of the assessments, in the overall sample, was also identified as an area of concern with 30% of assessments being rated as below a good standard. For the child protection cases sampled, this was lower still at 56%. (4.2.2) Whilst the briefing sessions provided to the practice teams covered the assessment of need and risk, it is evident from the findings that more action is required to improve the standard of assessments.

5.2.3 A good summary of concerns, needs and risks was not found in 23% of the overall sample and 29% of the child protection cases. *(4.2.3)* This is an important part of the assessment which requires improvement, particularly given feedback from children's panel members and reviewing officers which placed importance on this section as a scene setting part of the document. Whilst the briefing sessions provided to the practice teams covered this area, it is evident from the findings that more action is required to lift the standard of assessments.

5.2.4 The audit showed that the view of the child / young person was not recorded in a significant number of cases (26% in both the overall sample and child protection sample). *(4.2.4)* The briefing session, and guidance provided to workers confirmed that the child's view section should always be completed, however this remains an issue.

5.2.5 Use of abbreviations (34%), and use of copy and paste (25%) was found to be an issue. This was the case within the overall sample and the incidence was slightly higher within the child protection sample. *(4.2.5)* These are areas

children's panel members and reviewing officers had stated affected the clarity of the assessment, and this feedback was provided to workers during the briefing sessions. It is evident, however, that more work is required in this area.

5.2.6 Despite there being an increase in the number cases with a child's plan, the 2017 audit saw a decrease in the number of plans considered to be proportionate to the level of risk and need. This was concerning in the overall sample (with 24% of plans not considered fully proportionate) and the child protection sample (with 30% of plans not considered fully proportionate). *(4.2.6)* Work is required to improve practice in this area.

5.2.7 The audit evidenced that 26% of cases, in the overall sample and the child protection sample, did not have a child's plan written in SMART format. *(4.2.7)* This was identified as a development area in the 2016 audit (where the result was the same), but no improvement has been noted.

5.2.8 The child's plan was not considered to be fully child focused in 22% of the overall sample and in 30% of the child protection sample. *(4.2.8)* This is considered a development area to ensure that the child is at the centre of all child's plans.

5.2.9 More work is required to ensure relevant agencies are contributing proportionately to the plan. *(4.2.9)* This was particularly the case for the child protection cases sampled, with 29% of cases not providing evidence of relevant agencies contributing proportionately.

6. Recommendations

6.1 The Communities and Families Management Team are asked to note the findings of this case file audit and consider the following recommendations:

6.1.1 Work with SCRA and the Review Team to receive real time information regarding the quality of chronology / assessment to provide targeted feedback to frontline staff during supervision.

6.1.2 Provide mandatory ANR and chronology training to all staff, and ensure that this training is available to new staff on an ongoing basis.

6.1.3 Offer peer mentoring to newly qualified staff and new employees of City of Edinburgh Council for an agreed period.

6.1.4 Work with quality assurance to identify the reasons why child protection cases are experiencing more issues with the quality of chronologies and assessments, and build an improvement plan.

6.1.5 Introduce mandatory sample audits by team leaders of cases to ensure that self-evaluation, as well as audit, lead to improvements in ANR quality.

6.1.6 Pilot peer led reviews of assessments. Use exemplar examples to improve performance.

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Appendix 1

COMMUNITIES AND FAMILIES - ASSESSMENT OF NEED AND RISK AUDIT OCTOBER 2017

FILE READING TEMPLATE – GUIDANCE NOTES

Introduction

These explanatory notes are designed to aid the process of case file analysis and should be used by file readers alongside the case file audit template. **The last Assessment of Need and Risk to be considered will have been completed in July / August 2017.**

Part 1 Case Record and Case Type

All sections should be answered.

Part 2 Assessment and Risk

Q1-2. A chronology of key events should be located within the assessment of risk and need and contain significant life events (e.g. birth of sibling, change of school / house / employment, change in family relationship etc.), changes to legal status, and any concerns which have been reported about the child / young person by themselves or others. A chronology of social work events / interventions is not acceptable as a chronology. A chronology should be present in all statutory cases and where the referral suggests significant intervention and for provision of services by the local authority.

Core elements of a chronology (from '*Practice Guide to Chronologies,'* Care Inspectorate 2017):

- key dates such as dates of birth, life events, moves
- facts, such as a child's name placed on the child protection register, multi-agency public protection arrangements (MAPPA) meeting, adult who is subject to adult protection procedures
- transitions, life changes
- key professional interventions such as reviews, hearings, tribunals, court disposals
- a very brief note of an event – for example, a fall down stairs, coming to school with a bruise, a registered sex offender whose car keeps 'breaking down' outside a primary school
- at the same time, the writer needs to provide enough information for the entry to make sense. Statements like: "…[the individual] behaved inappropriately…" do not necessarily have sufficient detail
- the actions that were taken
- not opinions – these may be for the case record, but the strength of chronologies lies in their reporting of facts, times, dates etc.

Using the above please rate the quality of the chronology using the scale below:

Excellent – You will be able to answer 'yes' to all of the above areas where they are appropriate.

Very good – You should be able to answer 'yes' to all of the above areas where they are appropriate. There are no weak areas and there are areas of real strength.

Good – You should be able to answer 'yes' to almost all of the above areas where they are appropriate although there may be a few weaker areas.

Adequate– You should be able to answer 'yes' to most of the above areas where they are appropriate but there may be some areas of weakness. An adequate chronology should demonstrate a basic level of professional competence.

Weak – You cannot answer 'yes' to more than half of the above areas where they are appropriate. Some key areas are weak,

Unsatisfactory – You can answer 'yes' to only a minority of the above areas where they are appropriate.

Q3. The AN&R should address the level and complexity of risk and need in relation to the child / young person and their family. The chronology should be a live document that should contain comprehensive and relevant information which informs the assessment.

Q4. A judgement should be made by the file reader whether the most recent assessment of risk and need is current and relevant to the needs of the service user.

Q5. The **Summary of concern, needs and risks** is an introduction, giving an overview of events, issues and interventions to date. As a chronology of significant events will be attached to the report, it is not necessary to give a full account of the family history. However, this overview of the history **must give sufficient factual detail to evidence any statements** about the child or family circumstances.

This summary must include:

- when child / family first known to the agency
- the key issues of need and/or risk
- patterns and seriousness of these issues.

Where an assessment is being undertaken at the request of the Children's Reporter, the summary **must** contain sufficient factual detail to enable the Reporter to frame grounds of referral, as appropriate.

The summary may also include:

- interventions by agencies to date, timescales and outcomes
- any previous formal and statutory interventions, e.g. child protection and Children's Hearing.

For children involved with social work for a long time this could lead to a very long summary of concerns, needs and risk and would be an example of an area where we would be using workers to consider using the chronology to support the assessment.

Q6. Assessment is not a static piece of work. Assessments must be revised and developed as new information becomes available or new events occur.

Q7. The recommendations must describe the action required to achieve a clearly articulated outcome for the child. If there is need for services or any significant intervention, the recommendations must always refer to a proposed **Child's Plan**, which will outline detailed action to be taken.

If the assessment is for a **Children's Hearing:**

1. Refer to the proposed **Child's Plan** to be complete as a draft and presented to the Hearing with this assessment report.
2. Give opinions and make a recommendation about the need for compulsory measures.
3. If the child / young person is to be accommodated with foster carers, **confirm that the carer is approved under the Fostering Regulations and include a copy of the carer summary** obtained from the Family Placement Team.

If the assessment is for a **child protection case conference (initial or review):**

1. Refer to the proposed Child's Plan to be complete as a draft and presented to the conference with this assessment report.
2. Give an opinion and make a recommendation on the need for the child's name to be placed or to continue on the Child Protection Register.
3. Make recommendation on the living circumstances of the child.

For all other assessments:

1. Refer to the proposed Child's Plan to be complete as a draft.
2. Give an opinion and make a recommendation on the main resources required to meet the desired outcome.
3. Highlight processes required, where and with whom the draft plan should be discussed, for example discussion at a named.

Q8. There are a number of factors which should be taken into account when **considering the quality of needs assessments.**

They may not all be relevant for every assessment, but assessments should always include appropriate analysis of the key factors. The assessment should:

- contain all relevant information including personal / family history and critical information about other family members (siblings and adults). where appropriate;
- be recent enough to take account of any changes in the child's needs;
- clearly identify the specific needs of the child / young person in the context of the needs of their carer(s) and family as appropriate;
- be structured in a meaningful way;
- be integrated with contributions from all relevant agencies as appropriate;
- include the views of the child / young person, their carer(s) and family as appropriate;
- address the communication needs of the child / young person fully (for example, language spoken, signs, symbols, speech and language therapy, braille or audio);

- include the views of other relevant agencies;
- provide an analysis taking account of up-to-date knowledge / theory / research etc;
- include a summary of previous support / intervention with the child / young person and family and the response to this, where appropriate;
- clearly set out options for meeting the child's needs with the advantages and disadvantages of each option clearly stated and resource requirements where appropriate and
- offer a clear recommendation on how the child's needs may be best met.

Using the above please rate how well you think the child's needs have been assessed using the scale below:

Excellent – You will be able to answer 'yes' to all of the above questions where they are appropriate. All of the areas are strong. The assessment describes the child's current needs exceptionally well and anticipates likely future needs, detailing any action required to compensate for past deficits or reduce future difficulties. An excellent assessment will demonstrate an outstanding level of professional competence.

Very good – You should be able to answer 'yes' to all of the above questions where they are appropriate. There are no weak areas and there are areas of real strength. A very good assessment should be of a high standard, describe the child's short and longer-term needs very well and identify actions to meet them. It should demonstrate professional competence which exceeds an acceptable level.

Good – You should be able to answer 'yes' to almost all of the above questions where they are appropriate although there may be a few weaker areas. For example, short term needs are outlined well but there is limited attention to anticipating future needs. However, a good needs assessment still should demonstrate an entirely acceptable level of professional competence.

Adequate – You should be able to answer 'yes' to most of the above questions where they are appropriate but there are some important weaknesses. An assessment rated adequate should demonstrate a basic level of professional competence. However, the assessment could be strengthened in the extent to which it describes and analyses the needs of this particular child.

Weak – You cannot answer 'yes' to more than half of the above questions where they are appropriate. Some key areas are weak, for example there is limited consideration of the particular needs of this child or a lack of clarity in identified what is required to meet identified needs. A weak assessment demonstrates a lack of professional competence in key areas and is unlikely to helpfully inform decision-making.

Unsatisfactory – You can answer 'yes' to only a minority of the above questions where they are appropriate. There are major weaknesses, for example key information is inaccurate or out of date and/or important areas of need for this child are overlooked. The assessment may not identify needs but not address how to meet them. An unsatisfactory assessment demonstrates a lack of professional competence and may compromise sound planning for children / young people.

Plans

Q9. The Child's Plan **must be completed** in all instances where the assessment recommends services or a significant intervention. The Child's Plan sets out the actions to be taken to meet the child's needs. It records the person responsible for taking each identified action and the timescales for this.

Q10-11 There are a number of factors which should be taken into account when considering the quality of the Child's Plan to manage risks. Please consider the extent to which there is:

- the most recent Child's Plan is current enough to be of use in informing day to day practice with this child / young person
- clarity about which agency and lead officer has responsibility for overseeing the plan to manage risks
- a clearly stated aim and desired outcome/s (albeit these may be short-term)
- a SMART (specific, measurable, achievable, realistic and time bound) list of actions
- clarity about who is responsible for each action, and by when
- clarity about how progress will be monitored and recorded
- a statement on how partners will review and monitor the plan and how they will communicate / collaborate with each other
- a statement about what partners will do if risks change (contingency planning)
- evidence of consideration of appropriate use of legislation, if required
- evidence of consideration of the need for statutory measures
- where appropriate, sign-off by the child / young person, advocate or family carer (where appropriate) and agency lead.

Q12. The Child's Plan must identify intended outcomes for the child and set objectives for work with the child, the birth family and the carers in relation to the **Wellbeing Indicators** and child's developmental needs.

Q13. The plan should reflect engagement and involvement of parents / carers stating what changes will be made and how they will be progressed and actioned.

User involvement

Q14. Evidence of involvement and inclusion of the views of children / young people in their care could be taken from case notes, minutes or reports reflecting a conversation with a child / young person and/or appropriate representative or worker. Details of this should be well documented in the AN&R. For children too young or not able to directly articulate their views, evidence of this could be from observations regarding behaviour. Older children may disagree with social work recommendations / plans and this should be voiced.

Q15. Evidence of the involvement and inclusion of the view of parent's / carers in relation to the issues in the assessment could be taken from case notes, minutes or reports reflecting a conversation with the parents. Details of this should be well documented in the ANR. If a parent disagrees with something in the plan or assessment, that should

be detailed but put it into a context of where the information came from, i.e. the parents deny any drug use, however their view of events is contradicted by the police report of the incident.

Any analysis of this conflict of views can be documented at in the summary and conclusions section.

Multi-agency Working

Q16. Involvement of relevant partner agencies in the assessment will be evidenced in the casenotes and should be reflected in the ANR.

Q17. Involvement of relevant partner agencies should be recorded in the plan and recorded in SMART format – see guidance note Q10-11 above.

Outcomes

Q18. Evidence of positive outcomes should include an improvement in the child / young person`s circumstances that is tangible and the outcomes can be identified, e.g. reaching developmental milestones, improved health and wellbeing, improved safety, improved attainment at school. Positive outcomes should also be recognised from the child / young person's perspective where they feel there has been an improvement.

Q19. File readers should take account of the various factors they have identified already in their scrutiny of the case file. Of particular relevance are:

- the chronology and if this is comprehensive, consistent and follows the child / young person's pathway from birth, is clear about multi-agency working and is a live document
- the quality of the assessment of need and risk and the extent to which this is reflected in the plan
- the achievement of objectives and outcomes.

Q20. Information should be written in plain English and organised in a way which assists understanding of the information and service given. See House writing style on the orb.

Writing essentials:

- keep your audience in mind at all times
- keep it simple and use everyday language
- avoid too many exclamation marks
- avoid strings of capitals as they are hard to read
- be accurate - check your spelling, grammar and content
- use the correct house style for dates, numbers etc (these are detailed in the ORB)
- use the active and not the passive. For instance, 'The Council agreed to underwrite the transport management costs'. Rather than 'it was agreed by the Council to underwrite the transport management costs'
- avoid formality - use 'we' and 'you' instead of 'the resident' or 'the tenant'.

Apostrophes are used to denote:

a) a missing letter or letters, e.g. "can't" instead of "cannot", or "it's" instead of "it is".

While it is appropriate to abbreviate words like this in some written communications, it is not appropriate in official documents, such as committee, court or case conference reports. You should therefore avoid the use of apostrophes in this way when writing reports.

b) possession, e.g. “the Council’s report”.

An exception to this is the possessive form of “it”, which has **no** apostrophe, e.g. “in its mouth”.

When writing plural possessives, the apostrophe comes after the “s”, e.g. “the pupils’ books”.

Apostrophes are never used to denote plurals as shown below:

INCORRECT	**CORRECT**
Councillor’s met today	Councillors met today
Many 1000’s of people attended	Many 1000s of people attended
The decision was taken in the 1990’s	The decision was taken in the 1990s
GP’s	GPs

Q21. Assessments should be concise and to the point but include all the relevant information.

Q22-23 Assessment is not a static piece of work. Assessments must be revised and developed as new information becomes available or new events occur. Copying and pasting can lead to conflicting information, duplication and a disruption to the flow / readability of the assessment. Assessors should avoid repeating information in different boxes and should leave the box blank if there is no new information to add.

Q24. Assessors should not assume the reader knows the jargon and terminology: abbreviations and people’s roles should be explained.

Abbreviations:

When using abbreviations or acronyms to refer to names of projects, organisations or bodies, etc., you should type out the name in full the first time it is referred to, putting the initials in brackets after it. Thereafter you can just use the initials.

Ampersands (&)

You should not use ampersands (&) in normal text in reports or letters. They can sometimes be used in tables, etc., but should never be used in headings or in the text such as the example below:

The Council agreed to fund the sports centre, the swimming pool & the playing fields.

Q25 Any additional comments

Please add any additional comments which are useful in relation to the practice within the case file.

If there are any questions when completing the audit please contact:

Pauline Rogers, 0131 553 8512 or pauline.rogers@edinburgh.gov.uk

A document of QA work and Key Findings

Children's Services 2013 - 2017

Strengths & Areas of Development

This document collates a summary of both strengths and areas for development from the following reports:

- LAAC Review Self-evaluation (2014)
- Multi-Agency Team Around the Family Practice Evaluation (2014)
- 'Stronger North' Complex Case Practice Evaluation Model (2014)
- Secure Accommodation Audit (2016)
- Children & Families Case File Audit (2016)
- Young People Who Persistently Offend Audit (2017)
- Practice Evaluations for 2013, 2014, 2015
- Practice Evaluation: Three Year Evaluation (2016)
- Best Practice, Domestic Abuse (2016)
- Domestic Abuse Audit (2017)

Strengths and areas for improvement were identified and extracted according to the reoccurring data and themes contained in the above reports.

1.1 Strengths

- **Good engagement** was identified with children, young people and their families. Practitioner commitment was an area of strength often in situations of initial resistance and hostility, where barriers had to be overcome and effective communication was initiated through open and honest dialogue. Effective communication based on respect and trust between practitioners and children and their families was evident. In the disability team, a range of communication tools were used to gain the views and wishes of children.
- **Assessments** were deemed to be of a high standard. There was evidence that the shared assessment process enabled a more effective and co-ordinated approach to addressing risk and need, with GIRFEC principles clearly underpinning the assessment process and interventions provided. Most professionals believed that their assessments had contributed to the overall understanding of the families' needs and that this was shared through multi-agency meetings.
- **Plans** were SMART and feedback indicated that they were based on well informed assessments and in many cases included an in-depth knowledge of complex family dynamics.
- A realistic rather than an over optimistic approach was evident when **managing risk** with insight into the long term impact of substance abuse, domestic abuse and neglect. Case notes and discussion highlighted the positive use of social work authority balanced with engaging with families and listening to their wishes.
- **Intervention** was based on theory and underpinned by legislation in many cases. There were examples of research and models being quoted and used to support children and their families i.e. Signs of Safety, The Three Houses Tool, GIRFEC and safe and together models.
- There was clear evidence of **multi-agency working** with both internal and external partners. There were many examples of good working relationships with `team around the child` planning taking place in an effort to improve the lives of children and young people. The role of the lead professional was seen as instrumental in co-ordinating any multi-agency assessment effectively. Effective multi-agency work was enhanced when professionals were clear about their own role and that of others and how they fitted into the overall plan.
- Positive **outcomes** were identified with examples including children being more settled, parental substance abuse well managed, families working together even in difficult circumstances and children in successful placements away from home. Other examples included children who had issues of truancy and were now attending school, parents had been given strategies for managing challenging behaviour and setting clear boundaries, and high-risk behaviours had decreased for some children due to engagement, planning and joint working practices. Young people in TcAc were seen to be making more positive choices and in many cases permanence planning resulted in children being placed with kinship carers, foster carers and adoptive parents, resulting in them reaching their potential and reducing the impact of long term harm.
- Support and **supervision** were mentioned as being a positive factor in cases being well managed with newly qualified workers being well supported with challenging child protection issues. Evidence suggested practitioners were receiving high quality supervision and being supported by their managers, who usually attended practice evaluation sessions.
- In cases of domestic abuse there is evidence that the cases allocated to **Safe and Together Champions** linked the perpetrators' patterns of coercive control to a wide-ranging analysis of the impact on the non-offending parent and the child. The worker's consistent attempts to hold the perpetrator accountable and partner with the victim resulted in a more accurate assessment of risk to the child and an ability to continue to engage positively with the mother. This practice exemplified many of the key principles and components of the Safe and Together model.
- There was strong evidence that staff pay close attention to the **views of children, young people and families** and that children and families are encouraged and supported to attend meetings and to take an active part in decision-making. There was evidence that professionals knew the child(ren)/young person well and could convey a good sense of the child's world. There were many examples of good communication with children, and of children being kept at the centre of the planning process.
- There is an identified need to ensure as much **consistency** of people and practice as possible. Families need a 'go to' key worker to support them and continue the work over the long term. In the case of the Youth Offending Scheme the ethos in the service is to always try and ensure that a case is re-

allocated to the previous worker. This allows the worker to establish a trusting relationship with both the young person and their family to ensure consistency of approach.

- **Early intervention** with children and family where needs were identified quickly, rather than waiting until a situation escalates, was seen by professionals as the best way to promote good outcomes. This, combined with access to the right resources at the right time, potentially avoided an escalation of issues and statutory measures being pursued. There is evidence of preventative work to keep the young person out of the Children`s Hearing system; reducing risk and meeting need.
- **Family Group Decision Making** was effective in getting families together in many cases and identifying support within the family that would not otherwise have been identified.
- In several cases, the benefit of the mandatory **chronology** on the current assessment template was acknowledged. It was commented that chronologies were often only shared at formal points in the process, e.g. core groups, Children's Hearings or meetings, but that it would also be beneficial to share at other transitional points. Professionals often used chronologies with families to help them understand their 'story' or journey over a period of time, which helped shift the focus away from intervention as a result of isolated, single events or episodes.
- Evidence of good standards of practice and decision making in **cases where a child / young person is admitted to secure accommodation**. Decisions to admit to secure accommodation were taken against clear criteria as identified within the legislation and there was evidence of strong communication with children / young people and their families. Recording in which decisions and assessments of risk were undertaken were of a good standard prior to submission to secure.

1.2 Areas for Development

- **Recording**; while there was evidence of good practice within case notes, this was not always translated into the risk and need assessment. Equally, the views and wishes of the child are expressed well in discussion with practitioners, but this is not always clearly articulated or reflected in written reports.
- **Chronology**; a large number of professionals involved reflected that the use of chronologies could be improved. The chronology is part of the Child Protection process, but this is not necessarily updated or shared if the child is removed from the CP register. There is no chronology within the GIRFEC Child Planning framework. There is a need to be able to contribute to chronologies on an inter-agency basis.
- **Risk assessment and safety planning** was not comprehensively undertaken in several cases. Increased face to face discussions would be beneficial to inform joined up assessment and child planning, where there were different perceptions amongst professionals about whether the needs of the child(ren) were being met, concerns that the care of the child(ren) was not good enough, multiple house moves across geographical and service boundaries, different perceptions/views about parenting capacity and parental mental health. A 'child's risk and need assessment' is not the same as a 'domestic abuse risk assessment'. References to 'risk' were noted throughout case files; however, it was not clear what was being used to assess this risk. In some domestic abuse cases risk assessment seemed to focus on the likelihood of a physical assault taking place while the child was present. Evidence-based risk assessment tools did not appear to be used. Where such assessments were provided by perpetrator programmes, they did not clearly inform the child's risk and need assessment and child's plan. It was not evident from the files that the potential risk, which perpetrators present to adult and child victims in future relationships, was considered.
- The **multi-agency assessment process** could have been improved. The identified needs of the parents were not always acknowledged or assessed by professionals; outcomes from interventions were potentially compromised as a result. Assessments of the adults by adult social work services were not always shared or not shared timeously with the Lead Professional (children's services) or other Team around the Family members. Questions arose regarding how up to date the information was within the shared assessment.
- Areas for development were identified in the **coordination of the assessment** i.e. the lead professional had not coordinated, the professionals involved appeared to be working in clusters. A clear plan, outlining roles and responsibilities for each professional should be agreed from the outset with clearly identified outcomes for the family members, with one person taking the role of co-

ordinator. There was a lack of clarity about roles and responsibilities and during periods when social work was not involved, it was not always clearly agreed who was in the lead professional role.

- **The Child's Plan**; many young people seemed to have limited understanding of the purpose of their plan and their role in developing the plan, some did not know if the Child's Plan would help them and others felt it would not help them. Areas for development include strategies to increase young people's understanding of the purpose of their plan and their role in developing the plan. In some cases, child's plans need to be more specific about what changes are expected around parental behaviour, particularly in relation to safety, appropriate relationships and attachments.
- One child - one plan; areas for future development include co-ordination of **Child Planning meetings** for all children in the family to involve a greater range of professionals and promote a shared understanding of the families' circumstances based on a holistic perspective of family function. Quality assurance audits noted an absence of regular Child Planning meetings, as well as professional participation and contribution to these. The school nurse is not automatically invited, where there are younger, pre-school age siblings/children living in the household. In addition, there was a lack of continuity planning for when the Family Nurse Partnership and the Early Years Centre cease involvement. There was a lack of clarity about child planning meetings where there were several children in the family; they are often set up for individual children, but are not always sufficiently family focused. It is necessary to embed Child Planning meetings into practice early in the intervention and at regular intervals to promote regular information sharing, joint assessment and planning.
- Preventative and **early intervention services** are not always planned or delivered in ways which sufficiently meet the needs of the most vulnerable children. Similarly, it was questioned whether the system was only protecting children who may be in immediate danger, as opposed to families where children are subject to long term chronic neglect. There was evidence that the trauma which the young people experienced may have been mitigated by earlier intervention. The need to recognise and respond to assessed need within geographical areas where there are recorded (high) levels of deprivation was highlighted.
- **Intervention**; the 'right services' for families are often not available. The audits variously found that, for example, a referral made to family therapy had also not been progressed by the family therapy team. Unreasonable delays in accessing many key services, such as CAMHS, were cited as potentially causing significant problems in terms of delivering effective services at the point of maximum need. Support packages offered by agencies should be available over the longer term to help create and sustain improvement, where appropriate.
- There was agreement that **communication** could be improved, acknowledging difficulties around part time working. The presence of an identified Lead Professional and communication between Named Person, Lead Professional, hospital and school were discussed as areas for improvement at the assessment stage by embedding regular information sharing sessions, joint assessment and planning meetings into practice at the earliest point. It was identified that information sharing out with working hours (i.e. weekends) presents a challenge to professionals. In addition, all Team around the Family professionals should be alerted following the decision/outcome of the initial referral discussion (IRD).
- **Review processes** need to be robust to allow effective planning and decision making and ensure parents' compliance with plans for cases of children in need. There should be regular and systematic multi-agency review meetings similar to those for children and young people who are looked after and accommodated or whose names are on the Child Protection Register. There were examples where the evaluation process helped consolidate thinking that the situation had gone on too long without sustained improvement and more formal measures were needed.
- Delays and difficulties in obtaining **foster placements** hampered attempts to put in place a more effective support package at an early stage. Placements broke down in several cases due to an experienced foster carer being unable to manage the young person's/child's behaviour. The need to recruit specialist foster carers to meet children's needs and ensure early intervention is a reality. In one sample, none of the long-term foster carers were able to manage the behaviours of the young people. Concern was raised in the evaluation group about capacity and resilience of foster carers to manage challenging behaviours - how much support is given to them when things become difficult. There is discrimination regarding the age at which young people are no longer seriously considered for fostering.

- Universal **barriers to effective practice** across all disciplines were identified, including; an expanding workload, fewer staff, less resources and less stability in services. Late allocation of Child Protection cases was seen to have a direct impact on outcomes for children.
- Insufficient use was made of **child well-being concern** forms. Some professionals were unaware that when a case is not allocated to social work they can refer concerns directly to the Children's Reporter.
- There was believed to be a training issue for Children's Panel members - **Children's Hearings** did not always make decisions that were seen to be in the child's best interests, but were swayed by strong parental advocates. There was concern that panel members did not trust professional opinion, although there was factual evidence to support recommendations.
- The lack of integrated **IT systems** creates unnecessary barriers to effective information sharing and communication between professionals and agencies. Third sector agencies, whose workers often spend most time with the family, do not have access to other recording systems. Recording of involvements on SWIFT was inconsistent in a large number of cases evaluated. Involvements were often out of date (had ended), missing or misleading (denote active involvement with family, which was found to be inaccurate) some professionals/agencies known to have been working with the family for a number of years were in some instances completely absent from the involvement tab. This theme also extended to relationships; some relationships were unclear or misleading.
- **Secure referral panel**; the relevant audit identified a lack of transparency in record keeping related to decisions made, particularly in relation to the availability of the minute (or minute extract) held within the young person's file or on the G Drive. There was no evidence in any of the files reviewed that the decision to admit or not admit the child / young person to secure accommodation had been recorded on a *Significant Occurrence Notification Form*.
- **Supervision**; there needs to be more focus and investment given to effective supervision arrangements, both for individuals and the Team around the Family as a whole.
- It was identified that the practice of SMART planning in relation to **domestic abuse** is not as robust as with other categories of case. There were unclear expectations of how the family should manage the domestic abuse and in some cases the victims of the abuse were held responsible or equally responsible for carrying out the plans.